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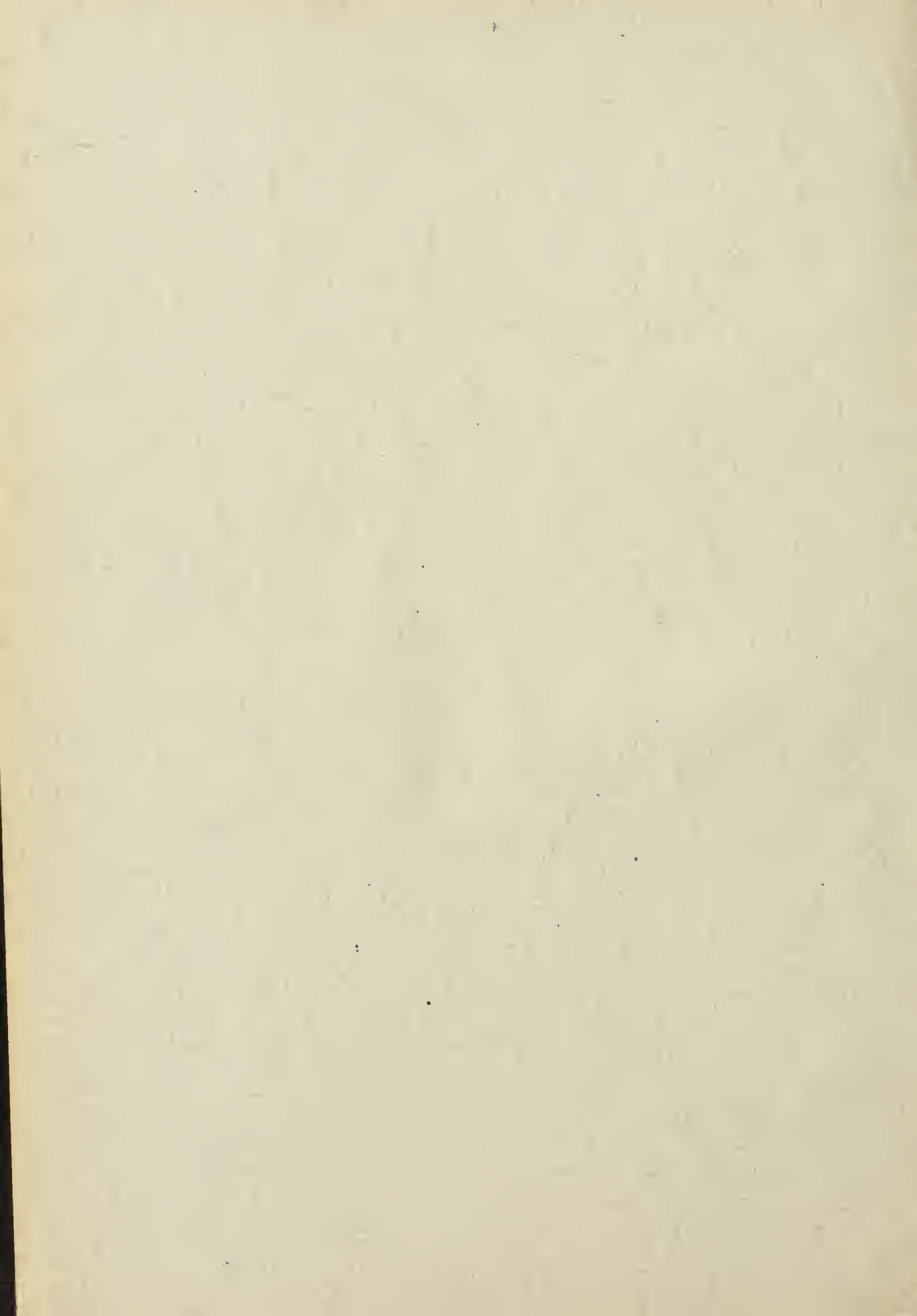
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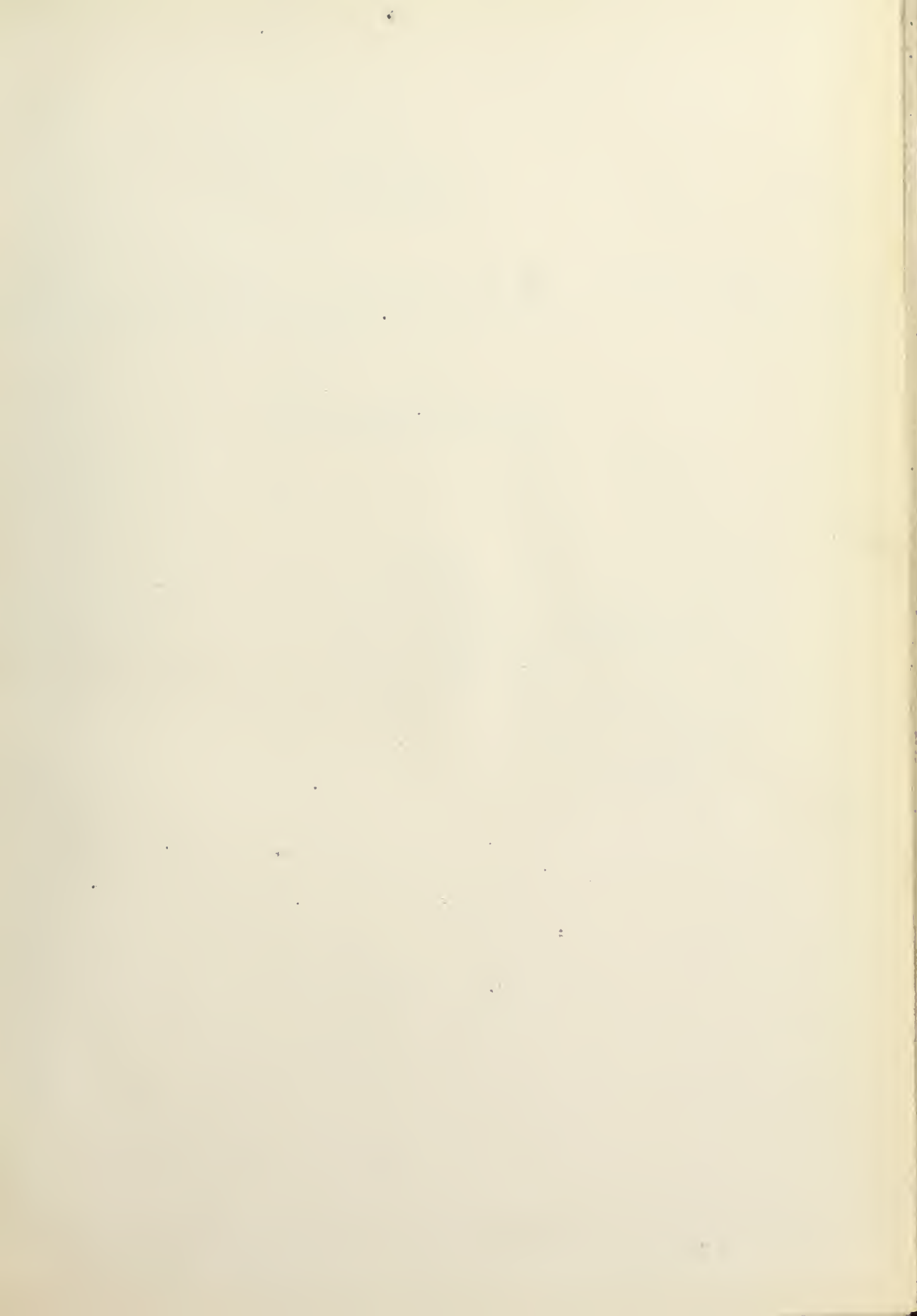
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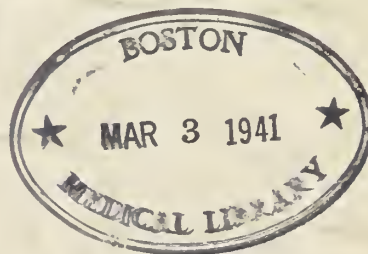
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The Connecticut State Medical Journal



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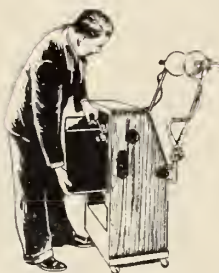


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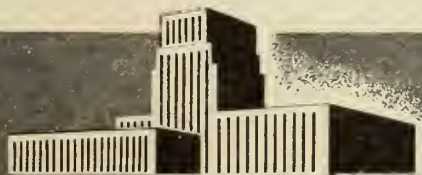
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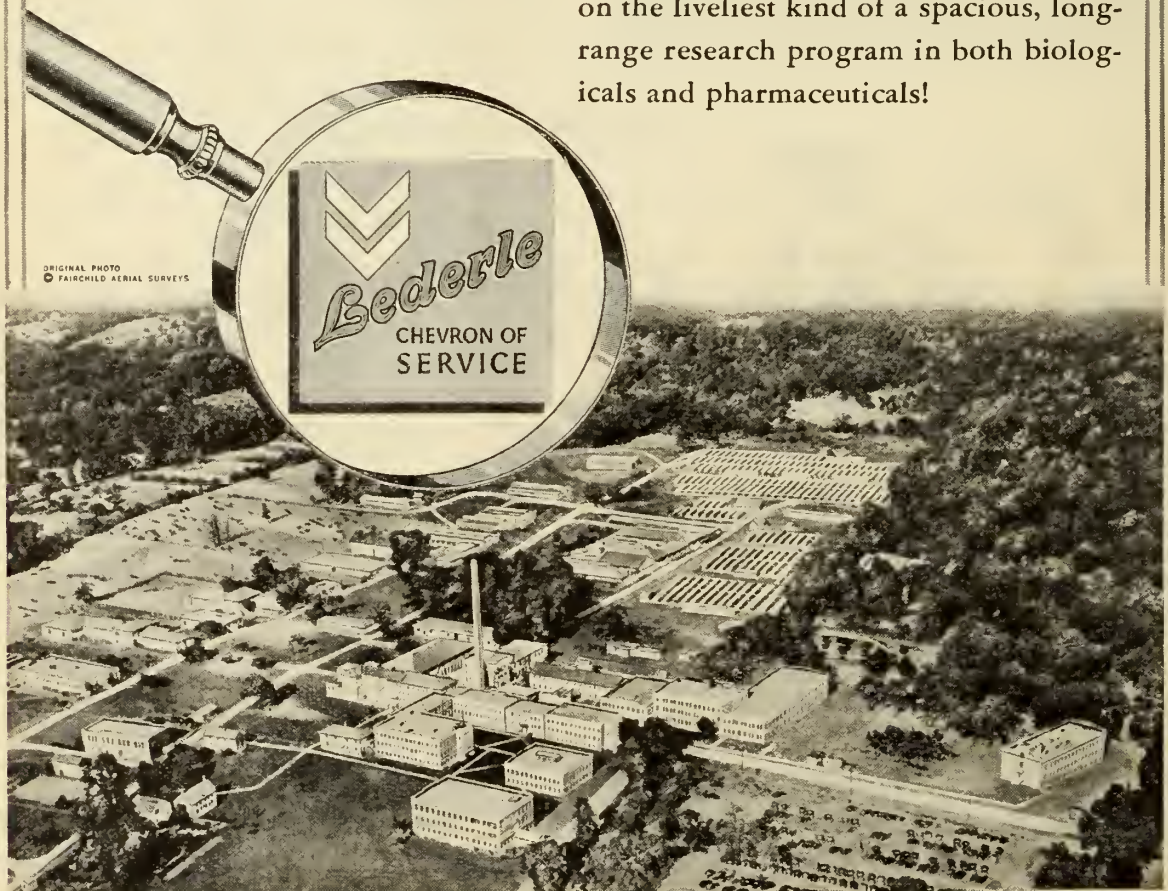
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Table of Contents

OFFICERS AND COMMITTEE CHAIRMEN:

Connecticut State Medical Society	4
Connecticut Hospital Association	4

ORIGINAL PAPERS:

Medical Care for the Underprivileged	C. E. A. Winslow, New Haven, Conn.	7
Aspects of Medical Defense in England	John F. Fulton, M.D., New Haven, Conn.	10
Connecticut Looks at Smallpox — Then and Now	Millard Knowlton, M.D., Hartford, Conn.	13
Rheumatic Heart Disease	C. F. Yeager, M.D., Bridgeport, Conn.	19
Indications for Therapeutic Use of Amino Acids	Lee E. Farr, M.D., New York, N.Y.	24
Use and Abuse of Physical Agents in Treatment of Chronic Arthritis —		
	Herman A. Osgood, M.D., Boston, Mass.	28
The Preparedness Program Today	Creighton Barker, New Haven, Conn.	36
Simultaneous Occurrence of Herpes Zoster and Varicella —		
	Lawrence S. Ward, M.D., Niantic, Conn.	41

CASE REPORT:

Osteogenic Sarcoma	W. Bradford Walker, M.D., Cornwall, Conn.	43
------------------------------	---	----

STATE DEPARTMENT OF HEALTH:

Have Adults Adopted the Tablet Form of Diet?	Elizabeth C. Nickerson, C. P. H., Hartford, Conn.	45
--	---	----

SPECIAL MESSAGES:

From the Governor	5
From the President, Connecticut State Medical Society	49

EDITORIALS:

Insurance Premiums in War Emergency	50
Vitamins — The Need for a Proper Perspective	51
The Lost Art of Prescription Writing	52
Citizenship — Licensure	53
What Is the Solution?	53
The National Physicians Committee After the Election	54

FROM THE SECRETARY'S OFFICE 55

SPECIAL MEETING OF THE HOUSE OF DELEGATES 56

CONNECTICUT HOSPITAL ASSOCIATION 58

MEDICAL PREPAREDNESS:

Organization of General Hospital No. 39	James C. Fox, Jr., M.D., New Haven, Conn.	61
---	---	----

NEWS FROM COUNTY ASSOCIATIONS 63

GENERAL PRACTITIONER'S FORUM 65

SPECIAL NOTICES 66

OBITUARIES:

Oliver Thomas Osborne, M.D.	B. Austin Cheney, M.D.	68
John Crandall Lindsay, M.D.	William John Moore, M.D.	70

QUARTO NOTES (Book Reviews) 71

PUBLICATIONS OF MEMBERS OF CONNECTICUT STATE MEDICAL SOCIETY

July 1, 1939 — June 30, 1940	73
--	----

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I am indeed grateful for your letter of congratulation on my election as Governor and welcome the opportunity of greeting the physicians and surgeons of Connecticut through the medium of their official Journal.

In times of emergency the medical profession has always been ready and willing to lend a helping hand. Such times are again at hand and I know that Connecticut's physicians will co-operate fully in the National Defense work of the numerous Selective Service Boards throughout the State.

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The Connecticut State Medical Journal

VOL. V.

JANUARY, 1941

No. 1

Medical Care for the Underprivileged

C.-E. A. WINSLOW,
New Haven, Conn.

The Author—B.S., Massachusetts Institute of Technology, 1898, M.S. 1899. A.M. Yale (Honorary) 1915; Dr. P.H. (Honorary) New York University, 1918. Taught Biology, and Public Health, Mass. Institute of Technology, in various grades, 1899-1910. Assistant Professor Bacteriology, University of Chicago, 1910, Associate Professor of Bacteriology, College of the City of New York, 1910-14. Anna M.R. Lauder Professor of Public Health, Yale School of Medicine since 1915. Member, Public Health Council, State of Connecticut, 1917 to date. Expert Assessor, Health Committee, League of Nations, Geneva, 1927-1930. Director, John B. Pierce Laboratory of Hygiene, 1933 to date. Past President, American Public Health Association and Society of American Bacteriologists.

When asked to prepare a brief article under the title "Medical Care for the Underprivileged" I considered, as one must in such cases, just what the terms of the assignment might mean. "Medical Care" needs no special definition, as between a teacher in a medical school and the readers of the Connecticut State Medical Journal; but the exact meaning of "Underprivileged" may be less clear.

My dictionary tells me that "Privilege" is a "Right, advantage, immunity, belonging to person, class, or office, special advantage or benefit." The underprivileged — in the context with which we are concerned — must, then, be those persons or classes who do not enjoy the right or advantage of enjoying the inestimable benefits of medical care.

In theory, there should be very few such persons or classes in the United States. In this country as a whole we have nearly enough doctors and nurses and hospitals (if they were well distributed), (though not enough dentists),

to give adequate care to all our people. Our Federal, State and local governments and our community chests and other voluntary agencies contribute liberally for the support of hospitals, clinics and nursing associations. The medical profession continues to maintain its splendid historic tradition of service to all who need care, whether they can pay for such care or not. Yet each of the many studies which have been made of this important problem has shown that a surprisingly large section of the American people, in actual fact, fails to enjoy the full privileges of medical care.

In 1929, at the peak of our national prosperity, such a study showed the following situations.

Families with family incomes of \$3000 or less had:

One half of the home, office and clinic contacts with physician;

Two-thirds as many cases hospitalized;

One third as many contacts with dentists;

One quarter as many hospitalized cases receiving special nursing care;

as were received by a similar number of families having incomes of \$5000 and over.

This is not because there is less need for medical care in the lower income groups; for all the studies show the incidence of illness actually increasing as one goes down the income scale. In spite of public contributions, in spite of the generous intent of the medical profession, there remains a serious economic barrier between the physician and the sick person who needs his care.

This barrier is certainly not the result of

excessive compensation for the professions and agencies concerned. Again, in 1929, the record shows that one third of all physicians in private practice in the United States had net incomes of less than \$2500 — a shockingly meagre reward for a profession requiring longer and more arduous preparation and involving more vital responsibilities than that of any other calling in the social state. Nor is the total economic burden involved beyond the power of our nation to bear. The actual amount of money paid for all forms of medical care in this country in 1929 was \$30 per person per year. This amount — if its collection and expenditure were properly organized — is almost adequate, according to a study made by Dr. Roger I. Lee of Boston some ten years ago, to pay for complete and adequate medical care for all the American people.

What is wrong with the picture? In the first place, the *average* expenditure of \$30 per person per year is an almost meaningless figure. Sickness is not a problem of averages but of individual emergencies. In the middle and low income groups (under \$3000) half or three-quarters of the families in a given year incur medical bills of negligible amount; but from 2 to 5 per cent of the families in these income groups actually have to meet charges for emergency illness amounting to a quarter or more of their annual income in a given year. This is where the shoe pinches. This is why such families — too proud to call on the charity of the state or the profession — do not call the doctor, do not go to the hospital. This is why a very large section of the American people are today "underprivileged" with respect to medical care. For the families with incomes under \$3000 included even in 1929 three-fourths of the families of the nation.

There is no single diagnosis of this problem, no single panacea for its solution. The social physician, like the medical man, must analyze his cases and prescribe according to the nature and gravity of the disease.

In the first place, the group of families with incomes over \$4000-\$5000 should be in position to meet even the emergency costs of illness from savings or legitimate borrowings; and they actually do this, as indicated by the fact that such families in fact do receive

reasonably adequate medical care. This group may be "discharged as cured" by the social diagnostician. For them, no modification of the present system of medical care on an individual fee-for-service basis is necessary.

A second group — perhaps including families with incomes between \$2000 (if the families are small) and \$5000 (if the families are large)— is in a different position. They should be able to pay the average cost of medical care in full; but they cannot be expected to meet from current income or by borrowing the cost of serious emergency illness. They want to pay the doctor and the hospital and they can pay the doctor and the hospital — if machinery is provided by which they can pool their group resources over a period of time. This is the field for Voluntary Insurance; and it is a field which has been explored with notable success during the past ten years. So far as hospital bills are concerned, there are now over four and a half million people in the United States who pay their \$6 to \$10 a year per individual or \$12 to \$24 per family into a common fund, and who are free to go to the hospital when they need hospital care, with the knowledge that the cost of hospitalization has been provided for. Patients and hospitals alike are receiving incalculable benefit from such prepayment plans.

Exactly the same principle can be applied, and every year is being more extensively applied, to the coverage of physicians' charges as well as hospital bills. Instead of paying \$10 for hospitalization bills alone, the prospective patient pays \$25—\$30 to cover medical, nursing and pharmaceutical as well as hospital charges. Reasonably complete medical care has been provided in this way under various auspices — of groups of physicians, of employers of labor, of organized employees, of cooperative consumer organizations. The professional effectiveness and the economic soundness of such plans — when properly organized — has been demonstrated beyond peradventure. They break down the economic barrier between physician and patient. They assure the patient of medical care and they provide for the practitioner an assured income. The advantages to the physician from such a plan are as great as those which the hospitals already enjoy.

The field of Voluntary Insurance is, how-

ever, limited to those families who can pay the average cost of medical care and can pay it with sufficient ease to be ready and willing to enter a voluntary prepayment plan. There is a third and very large group in our social order which can not satisfactorily be covered by such a program. These are the families with incomes ranging from perhaps \$750 to \$2000. They cannot pay even the total average cost of illness; but they can pay part of it. For this group, the only hopeful program which has been suggested is Compulsory Insurance. Under this plan, wage-earners below a certain income level are required to contribute from their weekly earnings a fixed sum to cover medical care. This contribution is supplemented by contributions from the employers and usually from the state to build up a fund to pay the doctor, the hospital, the nurse and the pharmacist. Such a system need involve no change in the relation between the individual patient and the individual practitioner. The only difference is that the physician's bills are paid and that the economic barrier which now separates the patient of low income from his family physician is broken down. It is difficult to see how these ends can be attained without supplementing what the worker can pay toward the costs of medical care and such supplementing can only be attained under a compulsory system. It should be pointed out, however, that "compulsion" is not applied to the doctor or the hospital but only to the worker and the employer; and it is significant to note that all of the great labor organizations of this country are unreservedly in favor of such a plan, and that no opposition has been expressed by the employer group.

Finally, there is a fourth and smaller group of families who cannot make any substantial contribution to the costs of the medical care they need. These are the unemployed and partially unemployed and the families (except very small families) with incomes of much under \$750 a year. This group can only be cared for, as at present, at public expense and by voluntary social organizations of various types. They are not today receiving the physicians' services or even the hospitalization which they need, as all competent studies of the

problem have indicated. The old slogan "only the very rich and the very poor receive good medical care" is — like most slogans — only half true. We need better facilities and better organization in providing for this group. The principle of payment from public or voluntary welfare funds is, however, inescapable.

To review the total picture, we have one section of the population who can more or less readily pay for adequate medical care on a fee-for-service basis. They are the "privileged." At the other end of the economic scale, we have a group who can make no substantial contribution to their medical bill. The population between these two extremes can pay the average cost of illness, either wholly from their own resources or by orderly supplementation by the employer and the state; but they cannot meet the cost of emergency illness when it occurs.

I must add one more word — with regard to quality as well as quantity of service. Medical care is not something you can buy by the yard or pound under formulae laid down by the Bureau of Standards. It requires a close personal relationship between physician and patient; and such a relationship can only be maintained or created when the patient knows his medical bills can be paid. It also requires almost infinitely complex knowledges and skills on the part of the medical practitioner himself. Under any plan of prepayment — or, indeed, without any plan of prepayment — the public has a right to demand the highest degree of skill which the advancing science of medicine permits. Guarantee of such quality of service can only come from one source — the medical profession itself. Whatever plans may be devised by the patient to pay his bills, the working out of plans for providing service rests with the doctors. The experience of the last decade shows great promise of achievement along this line through the organization of groups of physicians affiliated with hospitals sharing a mutual responsibility for the relation of the family physician and the specialist and for the rendering of service of the highest quality. Such forms of organization well deserve the consideration and perhaps the experimental study of the physicians of Connecticut.

Aspects of Medical Defense in England

J. F. FULTON, M.D.,
New Haven, Conn.*

The Author—B.A. 1921, M.D. 1927, Harvard University; Rhodes Scholar, Oxford, 1921-1923 (B.A. 1923, M.A., Ph.D. 1925). Peter Bent Brigham Hospital Boston, Surgery (under Dr. Harvey Cushing) 1927-28; Fellow, Magdalen College, Oxford, 1928-30; A.M. 1929 (Hon.) Yale; LL.D. 1938 (Hon.) Kenyon College. Sterling Professor of Physiology, Yale University School of Medicine, New Haven, 1930.

Doctor Fulton has just returned from England where it was his privilege to study first hand the various defense problems.

I. Mechanized Equipment

It is generally conceded that France in 1939 was far better prepared than in 1914, but prepared only for a repetition of the static type of conflict which characterized the first World War. This was true in her medical defense as well as in her defenses on the Maginot Line. She was wholly unprepared, however, for aerial warfare, for the rapid advance of mechanized troops, or for the casualties strewn over many miles of the spearheaded advances of the mechanized columns; a man who was injured and no longer ambulatory was as good as dead.

The British had things somewhat better in hand, with transfusion units on lorries, mobile neurological teams, and certain other motorized first-aid teams. The base hospital equipment and the casualty clearing stations were for the most part on wheels, but even these preparations were of little value in the face of the enemy's swift advance in France and their own rapid retreat during the Battle of Flanders.

In retrospect, the experience in Flanders and at Dunkerque indicates that the British had made a highly significant move in the right direction, and in the light of this experience, they are convinced that more of their medical equipment must be placed on rapidly moving wheels capable of action at a moment's notice; certainly no expeditionary force can safely be sent to the Continent or to any part of the British Empire unless it has mechanized and possibly armoured medical equipment. First-

aid units, transfusion units, surgical operating trailers, casualty clearing units and base hospitals must all be conceived and organized on the circus principle.

There has been a strong tendency in this country to organize medical defense on the basis of World War No. 1. We tend, in our paper organization, to place huge general hospitals and base hospitals in a certain geographical situation and then like Frenchmen, arrange in our mind's eye to have the theater of military operations at a convenient distance from our paper base hospital. This type of organization and thinking is as outmoded as the paper on which it is drawn. Large base hospitals are a thing of the past; they have a high affinity for bacteria and bombs, and they tend to become, as in the last war, centers of epidemics devastating both to the military and the civil population.

The great principle of military and medical organization operative at present in England, and also among the Axis powers, is *dispersion* of all forms of equipment, military as well as medical. No large hospital buildings have been constructed by either side; small ward barracks widely distributed are the order of the day. They have cut down mass epidemics and curtailed casualties from bombing raids, and dispersion has become also firmly ingrained in the arrangements for troop accommodations, as well as in the plans for the medical services. In these respects we must heed their example, and perhaps also recall that after Japan invaded China her troops within six months had penetrated a distance equal to that from Savannah to Kansas City. We must not lose sight of the fact that a successful invasion attempt would involve the use of rapidly moving columns in which the front line might move several hundred miles in a single day. This likewise would be true, we hope, of any offensive operations we might be called upon to undertake.

*Laboratory of Physiology, Yale University School of Medicine, New Haven, Connecticut

II. Bombing Injuries, Shock and Blood Substitutes

The English have also had to face on their shores the consequences of widespread bombing casualties; they have had, in addition, to organize for a possible invasion attempt. Their experience with bombing injuries is highly important to any program of medical defense, for the casualties are similar to those experienced on naval military craft — the type of injury which we would be the most likely to encounter in the event of military operations, whether of an offensive or defensive character.

In the last war there were many incidental records of individuals found dead in the vicinity of a bursting shell without evidence of external injury. This type of casualty has been alarmingly frequent among the bombing casualties in London, and it has drawn attention to the medical problem of the nature and treatment of such injuries. In addition to many deaths, there have also been numerous instances of individuals who, although surviving primary blast, have experienced profound circulatory collapse and other symptoms associated with traumatic shock.

In an earlier number of this journal, Dr. Weld has reviewed the experimental work of Dr. Zuckerman on blast, and also the clinical observations of Dean, Thomas and Allison, reporting from a Royal Navy Auxiliary Hospital (*Conn. State Med. J.*, October 1940, 4, 603-604). Zuckerman finds that when animals are placed at varying distances from a high explosive, the concussion wave generally kills monkeys, rats, guinea pigs, mice, etc., if within 18 feet of the explosion. Autopsy examination of those who have succumbed gives evidence of injuries to the lungs and to other abdominal viscera and occasional petechial hemorrhages in the brain, but these changes of themselves would scarcely be sufficient to account for death. Some other factor must be involved, and from various lines of evidence it would appear that the animals experience a circulatory collapse accompanied by varying degrees of cerebral concussion.

Denny-Brown and R. Russell (*J. Physiol.*, in press) have recently found that when the head is given a *sudden acceleration in space* as by a blow with a hammer, circulatory collapse occurs if the blow is severe and accompanied also

by symptoms of concussion. This, they believe, is due to temporary disorganization of the autonomic nervous system. They insist that all the symptoms of primary shock may occur following blows restricted to the head alone. The degree of acceleration essential for such symptoms has not yet been measured, but it is obvious that corresponding degrees of acceleration may develop as a result of proximity to a high explosive shell.

Treatment. There has been much discussion concerning the nature of the circulatory collapse seen after air raid casualties. It is accompanied by a slow pulse during the first hours, considerable hemal concentration, general diminution of blood volume, contraction of the spleen and other symptoms indistinguishable from surgical shock. Occasionally patients are encountered who remain in good condition until several hours have elapsed, and who then suddenly experience profound circulatory collapse. Such patients generally have had a crushing injury somewhere in the soft parts of the body, often from falling debris. Only one therapeutic measure has been agreed upon by all who have had experience with such cases, namely, they must have an immediate transfusion, of whole blood, if that is possible, or of one of the blood substitutes.

Blood substitutes. There is no widespread unanimity of feeling at the moment in England concerning the best blood substitute. Blood banks of whole blood were given up soon after the beginning of the present conflict, because it was proved impracticable to store it longer than 2-3 weeks. The Medical Corps of the British Army since that time have been partial to the use of whole plasma, and several units have been developed to prepare plasma in large quantities. Similarly, dried serum has also been prepared and is being used in the field.

There is no doubt that serum dried by the freezing method of Mudd is more readily shipped and handled than any of the liquid substitutes, whole plasma or serum. But an interval of time must inevitably elapse for the serum to go into solution, and preparation of sterile saline often presents difficulties in war conditions. These are the considerations which have caused the British Army to favor a liquid form of blood substitute.

Bombing injuries. In addition to injuries

from primary blast, the British have been obliged to contend with all manner of physical injuries resulting from falling debris and from high velocity fragments of shells and bombs. There have also been many instances of severe burns among airplane pilots and naval personnel. The blackout has brought still another category of injury and the hospitals throughout England are filled with the most varied and often bizarre injuries incident to night motor accidents, and also simple collision of ambulatory human beings with one another and with pins, trees and fences; and there have been many broken legs and pelvises from falls off curb stones, down stairways and into bomb craters and debris. The only type of injury that is essentially new is that caused by the high velocity (and generally very small) shrapnel fragment. The casement of the bombs used currently by the German Air Force splinters much more extensively and minutely than the bombs of the last war, and an individual may become literally peppered with 100 or more high velocity fragments. They travel at a rate which heats them and insures their sterility, and their velocity is often sufficient to penetrate the skull even though the fragment may have a diameter of less than two millimeters. When striking bone, such fragments generally become deeply embedded but do very little damage. When striking soft parts, however, they are likely to cause destruction out of all proportion to their size, *e.g.*, in the larger muscles or in the viscera.

Orr-Trueta immobilization. Open wounds of the extremities and lower trunk are treated routinely in most parts of England by plaster immobilization following thorough debridement. So impressive was the English experience with immobilization at Dunkerque that all those who had any doubt of its effectiveness were quickly won over. Dr. Trueta, who put the procedure to thorough test during the bomb-

ing of Barcelona, is now at Oxford working in the Department of Pathology under Professor Howard Florey. He believes that the effectiveness of immobilization lies in paralysis of lymphatic drainage, and he is about to publish his series of impressive experiments which prove conclusively that animals can withstand overwhelming infections if their extremities are immobilized immediately after the microorganisms have been injected; but the animal succumbs from spread of the infection if movement is permitted.

* * * *

One cannot write of medical defense in England without making some reference to the extraordinary morale encountered on every side — in the armed forces, the civilians, and more especially among patients in the military hospitals; and it is no doubt significant in this connection that there have been surprisingly few instances of war neurosis. Some shattered men broke down after Dunkerque, but these, for the most part, quickly recovered. Those who were slow to respond to ordinary measures of rest and reassurance are said to have been greatly helped by testosterone propionate.

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MEDICAL INDEX

A publication under the above title has made its appearance, apparently to present to the profession and to hospital executives the latest in equipment. It is very well printed, not so well edited, but contains cuts of a large number of new products described. A few courageous individuals, physicians and hospital administrators, have placed want ads. in its columns. It is not a publication every physician will want to subscribe to but at the same time if it is continued as a disseminator of all that is new in the instrument and medical equipment field it should be available to any and all physicians who make such purchases.

GOT A MATCH?

You don't need to have, to test for urine sugar with the new "Galatest" method, which dispenses with the need for bunsen burner and other laboratory equipment. A single drop of urine on a few grains of Galatest powder instantly reveals the presence or absence of sugar. You will like it, doctor, and so will your nurse and diabetic patients. Price? Fifty cents for approximately one-hundred tests. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

Connecticut Looks At Smallpox, — Then and Now

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The Sesquicentennial of the Connecticut State Medical Society will be celebrated at Middletown in 1942. In anticipation of that event the *Journal* is publishing a series of historical papers on different phases of medical history in the eight counties of Connecticut. The following from the pen of Doctor Knowlton is the third in this series. (*The Editor.*)

The Author—1902, Indiana Normal School, M.D., 1905, Indiana Medical College, C.P.H., 1918, Harvard University School of Public Health, Director, Bureau of Preventable Diseases, Connecticut State Department of Health, 1923 to date.

According to Galen the ancients believed that inflammatory diseases like erysipelas and smallpox were generated from bile. More than a thousand years ago, Rhazes, an Arabian physician, wrote the first treatise ever written on smallpox in which he said that "smallpox arises when the blood purifies and ferments, so that the superfluous vapors are thrown out of it." At present, smallpox is classed as a "virus" disease, and we hope to know sometime whether viruses are living entities or chemicals.

One factor in the smallpox problem has persisted throughout the ages. From ancient times smallpox has been recognized as a pestilential disease much to be feared. That great fear of the disease existed during the early days of American history is illustrated by the following excerpt from the records in the Historical Collection at the Library Association, Cornwall, Connecticut, kindly sent in by Miss Emily Marsh, Librarian:

"Whereas the Small Pox hath broken out in the Town of Cornwall and Mr. Ebenezer Jackson is now infected therewith and is Sick in a Small House belonging to Mr. Noah Rogers, near to said Rogers dwelling House and cannot be removed without exposing his wife; and whereas Sundry Persons have been greatly exposed to take the Infection from said Jackson before it was known that he had it — In order therefore to prevent (as much as may be) the further Spreading of said Disease, it is ordered and directed by the Subscribers that all Persons who have been exposed to receive the Small Pox from said Jackson and have or

may receive the same by Innoculation Shall have the Same in the house where said Jackson now lies, or in the dwelling House of Mr. Noah Rogers and Jefse Hyatt, that no Nurses or Tenders shall be more than 15 Rods from the House where the infected Persons are—that no Person or Persons who are not Nurses or Tenders to the Sick shall come within 15 Rods of the infected House except Capt Noah Rogers who may come within four Rods and that no Person or Persons do or shall pass the infected House in the Road or Highway until it be thoroughly cleansed, it is ordered that a fence be erected across the Highway at the Corner by the old School House and a Pole not less than ten Feet high to be Set up, on the Top of which shall be a white Cloth fastened not less than two Feet Square and that a Fence be erected across the Highway North of Mr Noah Roger's dwelling House Somewhere a little North of Said Rogers's Cyder Prefs, with a Pole and Cloth erected as directed for the South Fence — That all Dogs and Cats that Shall or may be found within the limits of aforesaid Shall be killed — It is further ordered and directed that no Person or Persons who may have the Small Pox in either of the houses aforesaid Shall leave or depart from said Houses until they are thoroughly cleansed, and have a Certificate that they are so cleansed, from the Infection from under the Hands of Doctor Joseph North Mefs: Oliver Burnham and Elijah Steele Junr or any two of them — and all Persons are hereby enjoined and required Strictly to observe the foregoing Orders, Rules and Directions, on Penalty of the Law in Such Case made & provided

Judah Kellogg Justice of Peace
Edward Rogers Justice of Peace

Cornwall May 5th A D 1801"

The word "innoculation" as used in the fore-

going record refers to smallpox inoculation and not cowpox vaccination as practiced today. The history of the development and extension of the practice of small pox inoculation constitutes one of the most fascinating chapters in the annals of preventive medicine. It has been said that the practice was introduced into England as a result of a letter from Lady Mary Wortley Montague, wife of the English Ambassador to Constantinople, written from Adrianople in 1717 to her friend, Miss Sarah Chiswell in London. However, it appears that Emmanuel Timoni, a Greek physician, wrote from Constantinople to Dr. Woodward in 1713 telling about the utility of inoculation in diminishing the mortality from smallpox. Also, Dr. Timoni wrote to the Royal Society in London in 1715 saying that inoculation had been introduced into the Capitol of Turkey from two of the Asiatic provinces bordering on the Caspian Sea forty years previously. Whether the practice arose first in India or China need not be discussed. Information concerning the procedure reached London from Turkey in the early part of the eighteenth century through various channels including those mentioned. Incidentally, in her letter to Miss Chiswell Lady Montague expresses distrust of doctors in the following words:

"I am patriot enough to take pains to bring this useful invention into fashion in England; and I should not fail to write to some of our doctors very particularly about it, if I knew any one of them that I thought had virtue enough to destroy such a considerable branch of their revenue for the good of mankind. But that distemper is too beneficial to them not to expose to all their resentment the hardy wight that should undertake to put an end to it. Perhaps, if I live to return, I may, however, have courage to war with them."

Lady Montague was mistaken in her judgment of doctors. Physicians did try out smallpox inoculation as a substitute for the disease acquired in the natural way, and accounts of their experience were published. In 1721 when smallpox threatened unusual havoc to the population of Boston, the Rev. Cotton Mather, having read favorable accounts of inoculation in the Transactions of the Royal

Society, recommended a trial of it to Boston physicians. At first only Dr. Zabdiel Boylston was courageous enough to try it out. He inoculated his own son and two colored persons in his family with success. Then he inoculated others. Opposition to the practice was so strong that Dr. Boylston was frequently insulted on the streets, was forced to secrete himself for more than two weeks, and afterwards to visit his patients only at midnight. However, the practice of inoculation eventually triumphed over opposition. During the 1721 outbreak, more than half the population of Boston had smallpox and one in 7 of those who had it the natural way died, while only one in 47 of those who had it by inoculation died. This is comparable to early figures for England of about one death in 50 from smallpox by inoculation. Later figures compiled on a large scale in England show an average of only about one death in 500 of those inoculated. This hazard was removed by the introduction of cowpox vaccination at the end of the century.

In the report of the Sanitary Commission of Massachusetts published in 1850, Lemuel Shattuck states that Dr. Boylston had inoculated 247 persons, while other physicians had inoculated 39, making a total of 286, and that only 6 of the total died. A table published in Shattuck's report gives the number of cases inoculated as 247. Apparently, those inoculated by physicians other than Dr. Boylston were not included in the table reprinted here as Table 1. Figures in this table giving relative fatality rates from having smallpox the natural way and having it by inoculation will show why inoculation eventually became popular. Also, the havoc wrought by smallpox in prevaccination days is illustrated by the occurrence of seven outbreaks in Boston during three-quarters of a century.

In 1798, an event occurred which made possible the complete conquest of smallpox. In that year Dr. Edward Jenner published his famous book on cowpox that introduced the modern method of vaccination. This practice soon reached America and Dr. Jenner's book was reprinted for Dr. Samuel Cooley in Springfield, Massachusetts, in 1802. As early as 1810 Dr. Samuel Schofield, "First Resident Surgeon of the New York Institution for the Inocu-

lation of the Cowpock," published "A Practical Treatise on Vaccina or Cowpock." In the preface of this treatise, he suggests the possibility that in America it may be discovered that cowpox is an effectual antidote for some other disease, and closes his preface with the following sentence:

"Perhaps, in this Western Hemisphere, there exists a malady, whose morbid secretion may arrest the rude blasts of pestilence, or check the direful ravages of phthisis pulmonalis!"

The importance of vaccination was recognized early by leading medical men on both sides of the Atlantic. Dr. Thomas Trotter retired from the position of Chief Medical Officer in his Majesty's Fleet and wrote an essay on the medical, philosophical and chemical aspects of drunkenness. In 1803 he dedicated this book to Dr. Jenner "whose labors go the length of saving annually half a million of his fellow creatures." This recognition was accorded to Dr. Jenner only after the subject had been carefully studied from various angles by numerous observers. For example, Dr. Woodville, physician to the smallpox and inoculation hospital in London, observed that in a number of cases vaccination was followed by a generalized eruption which could not be distinguished from smallpox. This was very disconcerting and difficult of explanation. Dr. James Bryce, one of the surgeons to the institution for the gratuitous inoculation of cowpox in Edinburgh, finally succeeded in solving the problem and published his observations in 1802. After much experience with only one vesicle following cowpox vaccination, Dr. Bryce had two children in one family develop generalized eruptions after vaccination. Finally, after the children were well on the road to recovery, the father confessed that there had been exposure to smallpox prior to vaccination. Dr. Bryce concluded that the generalized eruption had resulted from smallpox rather than cowpox vaccination. It appears also that some of the observers had transferred material from vesicles occurring in a generalized eruption to the persons newly vaccinated and had thus transferred smallpox virus instead of cowpox virus. This would readily account for the generalized eruption observed in so many

cases. At the present time it is recognized that on rare occasions a generalized eruption may result from cowpox vaccination of persons who are allergic.

On the whole, Dr. Bryce's discussion of the immunity aspects of the problem is surprisingly modern except in terminology. He even developed a test to prove that vaccination is effective. He vaccinated a child on one arm and a week later vaccinated the same child on the other arm. The second vaccination was much milder but it appeared more quickly and reached its height about the same time as the first, and both declined in about the same time if the first vaccination were effective. Dr. Bryce published colored plates in 1802 to demonstrate the validity of this test.

It is of interest to note that Jenner did not discover the efficacy of cowpox vaccination in protecting people against smallpox. It was a matter of common knowledge in many parts of England and elsewhere that persons who had cowpox would not have smallpox. The practice of inoculation with cowpox to protect people from smallpox had been carried out in many places before Jenner's time. Jenner merely tested out the procedure, found it effective, assembled some data in regard to the matter and published his results in a manner that attracted attention. Thus, Jenner's fame rests on the fact that he was a good publicity man rather than a discoverer. Publicity is important to preserve knowledge from being lost and forgotten. For example, smallpox inoculation is said to have been a customary practice in Wales before it was introduced into England from Turkey. Also, a similar custom is said to have prevailed in some parts of Denmark in the fifteenth century. However, the practice had to be introduced from Turkey before it was accorded general recognition.

Before the introduction of smallpox inoculation in England during the early part of the eighteenth century, it was known to cow doctors and farmers in various parts of the country that an attack of cowpox would protect against smallpox. However, they did all in their power to keep it a profound secret lest it should hurt their milk business. When smallpox inoculation began to be extensively practiced it was the common observation of inoculators that

it would not "take" on persons who had previously had cowpox. Such celebrated men as Sutton and many others made this observation. The Suttons are said to have inoculated about 40,000 people throughout London and many parts of England. It remained for an obscure country practitioner to introduce vaccination and give the world a method by which smallpox can be definitely prevented.

Dr. Benjamin Waterhouse of Boston was instrumental in introducing vaccination into America. He received a copy of Dr. Jenner's work early in 1799, and in March of that year published a brief article on the subject. Not long afterward, he brought the subject to the attention of the American Academy of Arts and Sciences, and John Adams, President of the United States, was also President of the Academy. Dr. Waterhouse was well acquainted with John Adams as he had lived with the Adams family while studying medicine in Leyden where Adams was American representative to The Hague.

As soon as Dr. Waterhouse could obtain some smallpox matter from Dr. Jenner's supply in England he proceeded to vaccinate his own children. Then he sent some of his children to the smallpox hospital near Boston to be inoculated for smallpox to prove the efficacy of the cowpox vaccination. One child was very carefully inoculated without results. By successful vaccinations in his own family, Dr. Waterhouse soon had popular support in favor of cowpox vaccination. When Dr. Waterhouse received a fresh supply of cowpox material from Dr. Jenner early in the spring of 1801, he forwarded some of the matter to President Thomas Jefferson, who with his son-in-law proceeded to use it in their own families and in those of their neighbors, totalling nearly 200 persons. The continued interest and efforts of President Jefferson were highly important in fostering the introduction of a new procedure into this country.

Dr. Waterhouse informed Dr. Jenner that cowpox existed in several parts of America where its power to protect against smallpox was not entirely unknown. In his letter Dr. Waterhouse says:

"At one of our periodical inoculations which occur in New England once in eight or

nine years, some people drive their cows to an hospital, near to a populous village, in order that their families might have the daily benefit of their milk. These cows were milked by persons in all stages of small-pox, the consequence of which was, the cows had an eruptive disorder on their teats and udders, so like small-pox that every one in the hospital, as well as the physician who told me, declared the cows had the small-pox."

Thus, it would appear that human smallpox may be conveyed to cows by contact in the same manner as cowpox is conveyed to man. Such a phenomenon would seem to be consistent with the view that both diseases are caused by the same virus and that the virus is so modified by passage through a cow as to greatly reduce its virulence for man. This would explain the advantages of cowpox vaccination over smallpox inoculation as the vaccination reaction is less severe and is not contagious except by direct transfer of the virus. That Connecticut cows had cowpox in the early days of vaccination is evidenced by reports from Dr. Elisha North of Goshen and Dr. Joseph Trowbridge of Danbury in 1801 that they had observed cattle with cowpox in their vicinities and had successfully used material obtained therefrom for vaccination purposes.

A part of Connecticut's contribution to the great mass of accumulated evidence that vaccination is effective in preventing smallpox may be of interest. A law was passed in 1822 authorizing local boards of education to require vaccination as a condition for attending school. This law has been on the statute books ever since and has been upheld by judicial procedure. Its utilization has been gradually extended until at the present time local boards of education for cities and towns comprising approximately half the population of the state make such a requirement. In many cities and towns that do not require vaccination, a large proportion of the children are vaccinated as a result of educational procedures. Death records for smallpox are available since 1856 and case records since 1895. Table 2 gives deaths from the disease recorded before cases were reported and Table 3 gives both cases and deaths reported since 1895. A comparison of figures

TABLE 1 — SMALLPOX IN BOSTON, 1721 to 1792, INCLUSIVE

(Report of Sanitary Commission, 1850, p. 70)

Year	Cases	Dths	Ratio per 100 of the population		Cases	Deaths	Ratio per cent	Inoculated		Ratio per cent
			Sick.	Died				Cases	Dths.	
1721	6006	850	54.6	7.7	5759	844	14.8	247	6	2.4
1730	4000	500	26.6	3.3	3600	488	13.5	400	12	3.0
1752	7669	569	48.9	3.6	5545	539	9.7	2124	30	1.7
1764	5646	170	36.4	1.1	669	124	18.5	4977	46	.9
1776	5292	57	44.1	1.0	304	29	9.5	4988	18	.5
1778	2243	61	16.6	.4	122	42	34.4	2121	29	.9
1792	8346	198	46.0	1.0	232	33	14.2	8114	165	1.8

TABLE 2 — SMALLPOX DEATHS IN CONNECTICUT, 1856 TO 1894, INCLUSIVE

Year	Deaths	Year	Deaths	Year	Deaths	Year	Deaths
1856	16	1866	0	1876	23	1886	0
1857	47	1867	5	1877	0	1887	4
1858	14	1868	7	1878	0	1888	4
1859	9	1869	6	1879	4	1889	0
1860	9	1870	9	1880	9	1890	12
1861	14	1871	39	1881	31	1891	1
1862	13	1872	57	1882	9	1892	4
1863	6	1873	67	1883	8	1893	3
1864	91	1874	56	1884	0	1894	13
1865	51	1875	24	1885	0		
						Total	667

TABLE 3 — SMALLPOX CASES AND DEATHS IN CONNECTICUT 1895 TO 1939, INCLUSIVE

Year	Cases	Deaths	Year	Cases	Deaths	Year	Cases	Deaths
1895	9	1	1910	0	0	1925	5	1
1896	3	0	1911	2	0	1926	2	0
1897	2	0	1912	329	0	1927	0	0
1898	1	0	1913	190	1	1928	170	0
1899	3	0	1914	95	0	1929	52	0
1900	2	0	1915	22	0	1930	0	0
1901	74	5	1916	175	0	1931	96	0
1902	344	14	1917	423	1	1932	92	0
1903	254	1	1918	94	0	1933	29	0
1904	6	0	1919	6	0	1934	0	0
1905	6	0	1920	2	0	1935	0	0
1906	75	0	1921	8	0	1936	0	0
1907	13	0	1922	447	6	1937	0	0
1908	6	0	1923	52	1	1938	0	0
1909	3	0	1924	100	5	1939	6	0
						Total	3198	36

in these tables for Connecticut with those in Table 1 for Boston during the eighteenth century will show conclusively the improvement in conditions as a result of vaccination. In considering the differences in these figures it should be remembered that Connecticut now has a population approximately one hundred times that of Boston at the time of the smallpox outbreak in 1792. It may be noted also from Tables 2 and 3 that there has been a great decrease in deaths in Connecticut from smallpox in spite of the very great increase in population. A part of this decrease in death rate is due to the mild type of smallpox that now prevails. Cases of the mild type are easily "missed" and so spread the disease to others who are susceptible.

From our present knowledge and record of accomplishment, we know that smallpox may be completely eradicated if one hundred per cent of the population keep themselves immune by vaccination. We know also that the best time for primary vaccination is in infancy when the child is under the supervision of a physician. This then is a job for the family physician. It is no longer necessary to send abroad for vaccine as did Dr. Waterhouse, or get it from persons recently vaccinated, or from cows as did some of the early Connecticut physicians. Smallpox vaccine put up according to modern methods can now be obtained free of charge from local health officers by any physician in Connecticut. Thus, many difficulties and hazards formerly experienced have been removed. A few points may be emphasized with reference to vaccination procedure.

1. Use only fresh vaccine. Outdated vaccine may have lost its potency.
2. Always keep vaccine under refrigeration. A temperature below the freezing point will not hurt it. It loses its potency rapidly at room temperature.
3. Give the primary vaccination under one year of age. If vaccination is delayed till an older age, give diphtheria immunization and perhaps other immunizing treatments before vaccination in order that the "collateral immunity" from other antigens may serve to modify or lessen the vaccination reaction.
4. Revaccinate five to ten years after the

first vaccination to maintain immunity. Should a virulent strain of smallpox be prevalent, revaccinate one year after the last vaccination as the virulent type is much more contagious than the mild type usually observed.

5. The multiple pressure method is the preferred method of vaccination.
6. The best site for vaccination is on the arm over the insertion of the deltoid muscle. This site is free from muscle beneath the vaccination area to increase the severity of the reaction by contraction while in use. Vaccination on the leg is not advised, and is permissible only if the patient can stay in bed for several days during the reaction.
7. Dressings should not be used. They are not needed and may be harmful. Airtight dressings are condemned as being dangerous. If the vesicle is ruptured later, a light gauze dressing that will permit a dry scab to form may be utilized.

It is earnestly recommended that all physicians give their patients the service of keeping them vaccinated against smallpox so as to eliminate the disease. In that way physicians can help realize the ideal expressed in a letter dated May 14, 1806, from President Jefferson to Dr. Jenner in which he says:

"You have erased from the calendar of human afflictions one of its greatest. Yours is the comfortable reflection that mankind can never forget that you have lived; future nations will know by history only that the loathsome small-pox has existed, and by you has been exterminated."

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Rheumatic Heart Disease

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About 75% of individuals with rheumatic infections exhibit subsequently some evidence of heart disease and 23% exhibit the clinical manifestations of congestive heart failure in one year after the onset of the infection. When symptoms of heart failure have set in, the course is very variable. Some do well but the tendency is toward repeated attacks, each of which may be of longer duration. Peculiarly enough, many of these patients are able to adjust their lives to the functional capacity of their hearts, even without bed rest.

The connective tissue of all the structures of the heart, namely the endocardium and valves, the myocardium, the pericardium and the coronary vessels are involved in varying intensities. Valve deformities may be slight and may not interfere in any way with the function of the heart. In such cases there may be entire absence of signs and symptoms.

Mitral Valve Disease

The mitral valve is the one most commonly affected in rheumatic fever. Stenosis and regurgitation of the valve are almost invariably combined. If the mitral valve lesion results primarily in stenosis, the left auricle and right ventricle bear the brunt of the burden and become dilatated and hypertrophied. If regurgitation is the chief defect, the left ventricle and left auricle are the ones that increase in size. In long standing rheumatic heart disease, all chambers of the heart may become enormously dilated and hypertrophied. With slight mitral regurgitation or stenosis, there may be scarcely any change in the heart size, but when either stenosis or regurgitation is extreme, the changes are marked. The murmurs may disappear when the recovery is satisfactory.

The pathognomonic signs of mitral disease are the history, the auscultatory signs and the x-rays. The murmur of mitral stenosis is diastolic, heard only at the apex, rumbling in character, low-pitched, ending in a snappy first sound, accompanied by an apical thrill in 75% of the cases. It is far more serious than regurgitation. The murmur of mitral regurgitation is apical and systolic.

The symptoms of mitral stenosis in advanced cases are dyspnoea, orthopnoea in severe cases, and a chronic productive cough which may be bloody. Massive hemorrhages may be seen. Palpitation may be present with either regular or irregular rhythm. Precordial pain is seen frequently. Pain in the upper right abdominal quadrant is due to a congested liver as a result of right heart failure. Cyanosis is due to decreased oxygen saturation of the arterial blood.

Aortic Valve Disease

Mild rheumatic infections may leave no deformity of the aortic valve, but severe and repeated infections tend to cripple the valve through adhesions of the cusps at their commissures, thereby producing stenosis of various degrees, or thru scarring, retraction and stiffening of the free borders of the cusps, thereby producing regurgitation. As in mitral diseases, both stenosis and regurgitation exist simultaneously, generally in varying degrees. Marked aortic regurgitation has a more rapidly serious effect than has marked aortic stenosis. The heart becomes very large with the simultaneous development of left ventricular hypertrophy, producing eventually the ox heart. The heart of "pure" aortic regurgitation is the largest and heaviest known.

Aortic regurgitation is shown by the presence of an early blowing diastolic murmur heard along the left sternal border at the level of the second and third ribs, or in the second intercostal space to the right of the sternum. The characteristic "Corrigan" pulse rises abruptly

and falls abruptly. There is a large pulse pressure due to regurgitation into the left ventricle. There is an alternate flushing and blanching at the distal ends of the finger nails with each cardiac cycle. The cardiac pain in aortic regurgitation is more frequent than the pain in mitral stenosis and may simulate angina pectoris. With left ventricular failure in aortic regurgitation there may be dyspnoea and orthopnoea.

Aortic stenosis is accompanied by a loud systolic murmur in the second interspace to the right of the sternum, with or without a thrill. The second aortic sound is often absent. Except for the complications of aortic regurgitation, mitral valve diseases and congestive failure, aortic stenosis in itself is not very serious.

Myocardial Disease

Rheumatic infection damages the heart muscle and lowers its functional capacity. Therefore cardiac failure may be due to the inflammatory changes in the myocardium, or circulatory as a result of valve defects and endocardial disease. An indication of the damage to the myocardium in active rheumatic infection is afforded by the great frequency of electrocardiographic changes, even though there may be neither symptoms nor signs of cardiac involvement. The taking of repeated electrocardiograms cannot be over-emphasized. As many as eight to ten cardiograms a day may be necessary to diagnose and treat myocardial disease.

The most frequent cardiographic findings are prolongation of the P-R interval and alteration of the Q-R-S complex, the R-T segment and the T wave. Other disturbances may be premature contractions of the auricle, auricular fibrillation or flutter, auricular or ventricular tachycardia, nodal rhythm, bundle-branch or sino-auricular block.

Management of Rheumatic Heart Disease

In treating rheumatic heart disease, the physician strives to inactivate the rheumatic infection and eliminate cardiac strain and failure. From a therapeutic point of view, three groups of cases may be differentiated:

1. Patients with rheumatic infection with no evidence of heart failure. These cases are

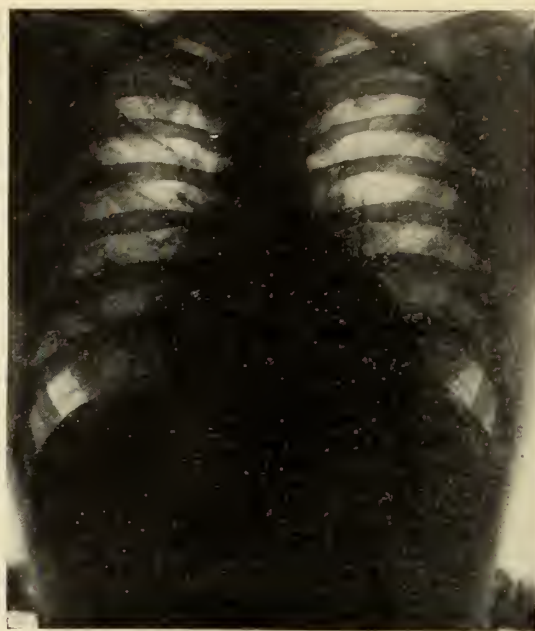


Figure 1.

Male, age 33, in an active phase of rheumatic fever, showing cardiac enlargement, rotation, and disappearance of the aortic knob.



Figure 2.

Same heart following eleven weeks of bed rest.

most common despite the fact that the myocardium is involved in all cases of rheumatic infection. Because of the absence of heart failure, these cases are

treated for the rheumatic infection per se.

2. Patients with fulminating rheumatic activity and heart failure in which cases the treatment is directed toward both.
3. Patients with long-standing rheumatic heart disease are treated for this condition only.

General Measures in Treatment

All patients with active rheumatic infection should receive bed rest. Many clinicians recommend a minimum of one hundred days in bed for the initial infection. Absorbent bed clothes are used because of perspiration. Painful joints should be swathed in flannel to avoid trauma. Diet should be ample and high in protein.

Drugs

The salicylates are the most valuable drugs in the treatment of active rheumatic infection. Experience has shown that they do not shorten the duration of the disease nor prevent its recurrences. They may, however, reduce the fever, swelling and pains in the joints. Sodium salicylate is administered in doses of 15 to 20 grains with an equal amount of sodium bicarbonate given hourly for eight doses to adults. Then the dose is decreased depending upon the symptoms and tolerance which the patient presents. Other drugs used are cinchophen, neocinchophen and amidopyrin. The value of prontosil and neoprontosil is as yet undetermined.

Removal of Foci of Infection

A very high percentage of cases of rheumatism or its exacerbations are initiated by sore throats. For this reason a good deal of importance was attached to the removal of tonsils in this disease. It is generally believed

now that tonsillectomy rarely shortens an attack of rheumatic fever and in some cases their removal causes serious aggravation. Many observers have found that there is little difference in the incidence of rheumatic fever in children who have had tonsillectomies as compared with those who have not. When the tonsils are definitely infected, it is wiser to postpone the operation until the acute infection has subsided.

Rationale of Bed Patients

A child or young adult exhibiting symptoms of rheumatic fever will require bed rest until all

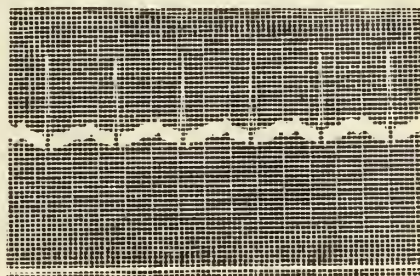


Figure 3.

Female, age 19, in the active phase of rheumatic fever, showing a prolongation of the P-R interval.

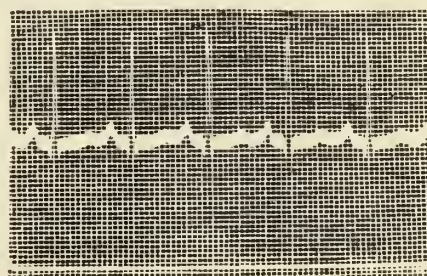


Figure 4.

Same as fig. 3, showing a normal P-R interval following 18 weeks of bed rest.

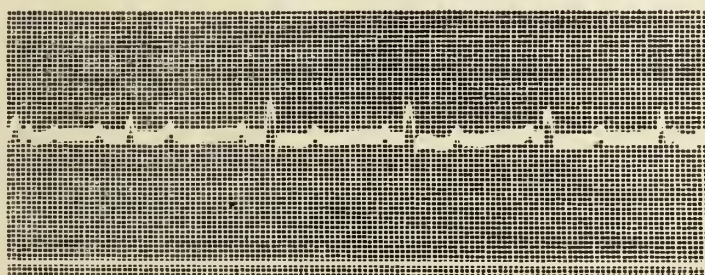


Figure 5.

Male, age 20, in the active phase of rheumatic fever, showing the Wenckebach phenomenon, a progressive decrease in the P-R interval from beat to beat.

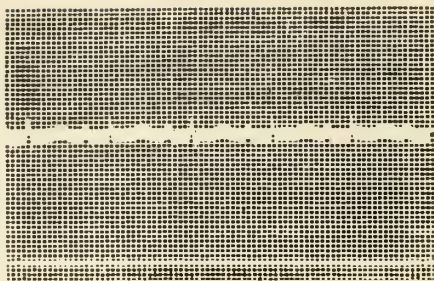


Figure 6.

Same as fig. 5, eleven days later, showing only a slight increase in the P-R interval.

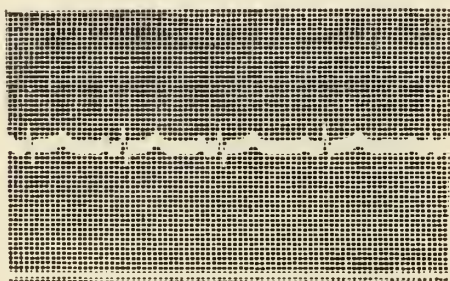


Figure 7.

Same as fig. 5 and 6, 10½ weeks later, showing a normal P-R interval.

symptoms and signs disappear. This is done to prevent permanent damage or minimize damage to the heart.

Before the patient is allowed out of bed, the following points should be observed in ruling out rheumatic activity:

1. The temperature of the patient should be normal for at least 1 month. A variation of 1.5 degrees during the day indicates definite activity, for example, the temperature may vary from 98.2 degrees to 99.8.
2. The night or sleeping pulse rate should be below 70. Pulse rates taken during the day are not dependable because of nervous factors.
3. Any noticeable degree of persistent anemia or leucocytosis may indicate activity.
4. A rapid sedimentation rate points to activity and may outlast all other criteria. It should be remembered, however, that heart failure tends to slow the sedimentation rate, and that the acceleration due to activity may be masked if cardiac insufficiency is present.
5. Body weight: In the presence of a palpable

liver any increase in weight can only be due to water, and indicates definite activity. An increase in weight in the absence of edema and a palpable liver is a good sign, therefore the liver can be called a "barometer" in determining activity. Because of fever, there is an increase in metabolism and a high protein diet is indicated. Meat, fish, eggs and cheese should constitute a large portion of the diet in all cases of rheumatic fever.

6. Any cyanosis or dyspnoea indicates definite cardiac activity.
7. Cutaneous manifestations such as various types of erythema multiforma, as well as subcutaneous nodules, indicates activity.
8. Painful joints.
9. Auscultation of the heart early in the disease should be done frequently because of rapid changes; some of which may remain permanent. It may be difficult to determine activity because of permanent cardiac damage. However, signs of failure definitely indicate active rheumatic heart disease.
10. Electrocardiographic abnormalities or changes towards abnormality are one of the best criteria indicating activity. The usual abnormalities were mentioned previously.
11. X-ray studies of the heart are necessary in all cases of rheumatic fever. Any increase in size as well as any increase in pulmonic markings indicates activity. In ordinary P-A views of the heart the diagnosis may be difficult because shadows overlies each other. Fluoroscopic studies or oblique x-rays are the only means by which the heart may be visualized intelligently; these studies bringing into view the individual chambers of the heart. When P-A views are taken, often the pulmonic markings are improperly evaluated due to faulty technique. Also, the position, size, and shape of the heart will be altered depending upon the height of the diaphragm which is lowered by deep inspiration.

These criteria will help determine and evaluate the activity of the disease. It is known, of course, that even the disappearance of all these criteria of activity does not necessarily mean that the rheumatic inflammation

of the heart has completely subsided, for the latter may persist in low-grade form for years and decades.

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INDUSTRIAL HEALTH ACTIVITIES

National preparedness has brought into the limelight many problems heretofore only very casually given consideration. On January 13 and 14 the third annual Congress on Industrial Health sponsored by the American Medical Association will convene in Chicago for discussion of some of these industrial problems. The program includes such subjects as "Disability Examination in Silicosis," a symposium on hand infections, another symposium on the availability of trained industrial health personnel, "Employment of the Physically Handicapped," "Respiratory Disease and Air Conditioning," a symposium on industrial ophthalmology, and "The Control of Syphilis in Industry." Speakers include such eminent authorities as Irvin Abell, Chairman of the Health and Medical Committee in the Council of

National Defense, Philip Drinker, Professor of Industrial Hygiene at Harvard, and Carey P. McCord, Chairman of the Committee on Air Conditioning of the A.M.A.

The Committee on Industrial Health of our own State Medical Society has been very active. At a meeting held in Hartford in November a program for the promotion of industrial health on a state-wide scale was presented to organized industry. The purpose of this plan is the conservation of man power under the national preparedness program in which opportunity is afforded to make Connecticut the healthiest State in the Union for the industrially employed. Doctor Clifford Kuh, chairman of this committee, has been requested to participate in the program of the Congress on Industrial Health to be held in Chicago this month.



24 HOUR TELEPHONE SERVICE FOR PHYSICIANS

The Medical Society of the District of Columbia has authorized the establishment of a twenty four hour telephone service beginning on December 1. The Society has granted a loan of \$1,000 to subsidize the Medical Bureau, as the service is called, during the first six months. More than 100 physicians have subscribed to the Bureau, according to *Medical Annals* for October. The goal of 200 members is expected to be reached before another directory is issued. The Bureau is offering two types of service, an Alternate Listing Service and a Secretarial Service. The former is the well known listing, "if no answer call", while in the latter service the physician's office is connected with the Bureau switchboard by a private wire. The Alternate Listing Service costs \$2.75 per month, plus 25 cents for listings in the directory; the Secretarial Service costs \$4.00 per month, plus cost of installation and rental of a private wire.

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(SEE PAGE 2)

Indications for Therapeutic Use of Intravenous Amino Acids[†]

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Technical advances in the past twenty years have made possible widespread and inexpensive production of fluids suitable for intravenous medication. The use of normal saline, Ringer's solution and glucose has become universal and the indications for administration of these materials have been thoroughly studied. About five years ago, Holt, Tidwell and Scott¹ reported the preparation of fat emulsions for intravenous administrations. With the very recent development of hydrolysates of casein suitable for intravenous use, for the first time it is possible to satisfy nutritional requirements entirely by parental administration of minerals, carbohydrates, fats and nitrogen.

In 1937 Elman² of St. Louis reported the administration of an amino acid mixture, casein hydrolysate, to patients with the purpose of providing an adequate and continuing source of nutritional nitrogen. Elman showed that with the preparation then available intravenous administration was feasible, and that nitrogen so administered was apparently utilized for the satisfaction of nutritional requirements. In 1939 Elman³ reported more extended observations on a group of patients largely comprised of individuals with inoperable carcinoma or with extensive surgical repairs of the gastro-

intestinal tract. This report confirmed his previous conclusion on the apparent adequacy of casein hydrolysate in satisfaction of nutritional nitrogen needs. During the past two years Shohl Blackfan^{4, 5} and their associates in Boston have been carrying out similar experimental observations on the capacity of infants to utilize intravenous amino acids. They gave the material to infants with diarrhea, pyloric obstruction, fibrosis of the pancreas and coeliac disease. The results obtained in these studies indicated that the infant was also able to utilize amino acids provided in a casein hydrolysate and that the incidence and severity of reactions resulting from such administration could be controlled. Other clinics have also made similar observations on a less extended scale. Both Elman, and Shohl and Blackfan used, as the prime indication for the use of intravenous amino acids, temporary inability of the patient to eat sufficient food to maintain himself in an adequate nutritional state. The one obvious and incontrovertible indication for use of intravenous amino acids is inability to take any food by mouth, this I shall call a *positive* indication. The urgency for amino acid treatment in such circumstances depends upon the patient's clinical condition and the probable time that he will be unable to eat.

If a patient is temporarily unable to take sufficient quantities of food by mouth and is in a state of, or threatened with, tissue nitrogen depletion, the desirability and urgency of treatment will depend upon the degree and estimated duration of his semi-starvation. This I shall term a *probable* indication for the administration of amino acids. That is, the indication is one of general supportive measures to improve the patient's condition and not absolutely required for maintenance of life.

[†]Read before the Connecticut State Medical Society, Hartford, Connecticut, May 22, 1940.

*From the Hospital of the Rockefeller Institute for Medical Research, New York.

The judicious and advantageous use of amino acids under these conditions will depend upon the skill, judgment, and ability of the attending physician. Thus far both indications, *positive* and *probable*, for the use of intravenous amino acids are based primarily upon the patient's inability to satisfy his nutritional requirements in the usual manner.

The third indication for the use of intravenous amino acids does not have the readily apparent relation to the patient's welfare that have the two already mentioned. It is based upon the demonstration of an abnormality in amino acid physiology. This abnormality is a decreased concentration of amino acids in the blood plasma. The demonstration of a deficit of a normal constituent of plasma is usually taken to indicate an inadequate supply of that substance, and presumes correction may be attained by furnishing that material or its precursors in larger amounts. Consequently, the demonstration of plasma hypoaminoacidemia I shall call a *presumptive* indication for intravenous amino acid therapy. The weight of this indication must be determined by actual experimentation and cannot be predicted solely from a consideration of the degree of deficit.

Farr has shown that the failure of children with the nephrotic type of Bright's disease to regenerate plasma when fed a diet approximately optimal for the assimilation of nitrogen cannot be attributed solely to loss of protein in the urine in all cases; sometimes severe hypoalbuminemia occurs with but slight loss of urinary protein^{6,7,8,9}. Further, rapid regeneration of plasma protein during recovery is, within wide limits, independent of the protein content of the diet. Farr and MacFadyen sought an explanation for these phenomena in a study of the plasma amino acids. They found that in nephrotic children there existed a significant lowering of the plasma amino acids which appeared to persist for the duration of the disease¹⁰. Additional observations by Farr^{9,11,13} and by Farr, Emerson and Futcher¹⁵ have shown this hypoaminoacidemia to be present in the majority of nephrotic children. The hypoaminoacidemia was not due to failure to absorb amino acids after a protein meal¹⁰. Farr⁸ and Farr and MacFadyen¹⁰ described characteristic metabolic changes which occurred

during acute febrile episodes with peritoneal symptoms but without infection which Farr⁸ termed "nephrotic crises." The most characteristic change was an acute exacerbation of the plasma amino acid deficit. When infection of the blood stream and peritoneum complicated a nephrotic crisis, the period of severe hypoaminoacidemia was prolonged.

The consistent demonstration of these changes in the plasma amino acid nitrogen concentration was made possible by the development of a new specific method for determining amino acids by Van Slyke and Dillon¹¹ which was applied to blood and urine by MacFadyen and Van Slyke¹². Older methods for determining blood amino acids are not specific enough to detect changes in every instance as has been demonstrated by Farr and MacFadyen¹⁰.

These observations of a chronic hypoaminoacidemia acutely exacerbated in nephrotic crises immediately suggested the therapeutic use of amino acids intravenously. The intravenous route was selected in our patients because of their prostration, vomiting and diarrhea during nephrotic crises and because it precluded any failure of absorption. During the past two years a group of twenty-five patients to whom amino acids have been given intravenously have been studied extensively. The same product furnished by Mead Johnson and Co. has been given throughout and was prepared for intravenous use as described by Farr¹³. Intravenous injections of casein hydrolysate were well tolerated by nephrotic children and the injected amino acids were not excreted in the urine but were retained and utilized¹⁴. After injection of 10 to 20 grams of casein hydrolysate intravenously, the injected amino acids were completely removed from the blood stream in one hour at which time the fasting level was regained no matter how far below normal this may have been. In nephrotic children injection of amino acids intravenously has had no demonstrable effect upon plasma protein concentration nor even upon the hypoaminoacidemia^{13,15} except during the first hour following injection. Although no effect upon the amino acid level in the plasma has been demonstrated, Farr, Emerson and Futcher have shown that casein hydrolysate given intravenously was at least equivalent to the same

amount of nitrogen given as protein in the diet¹⁵.

Although thus far neither correction of the specific metabolic fault of hypoaminoacidemia nor increase in plasma proteins has been attained by injection of intravenous amino acids in nephrotic children, definite beneficial results in the treatment of nephrotic crises complicated with blood stream infections have been noted in this clinic. Before amino acids were available, our mortality in nephrotic crises complicated with pneumococcal bacteremia was 60 per cent. The treatment of the blood stream infection with highly potent anti-pneumococcal serum of rabbit or horse origin did not seem to alter the outcome of the episode favorably, though in most instances the blood immediately became sterile. These patients were also vigorously treated with general supportive measures as transfusion and intravenous glucose. During the past two years in this clinic we have followed the *same* therapeutic regime for the treatment of these complicated crises with the addition of intravenous amino acids. Each patient was treated immediately upon developing a crisis and liberal use of intravenous amino acids was the rule until his plasma amino acid nitrogen rose above 2.5 milligrams per 100 cc. plasma, the critical level of Farr and MacFadyen¹⁰. In the last two years sulfanilamide was used as an adjunct in the treatment of some of the crises complicated with hemolytic streptococcus bacteremia and also in *B. Coli* bacteremia. In this period we have treated with intravenous amino acids, nine nephrotic crises complicated with pneumococcal bacteremia of which five were treated with amino acids alone, three nephrotic crises complicated with streptococcus bacteremia of which two were treated in combination with sulfanilamide and one was treated with amino acids alone, five nephrotic crises complicated with *B. Coli* bacteremia of which three also received sulfanilamide. One patient developed a *B. Morgani* bacteremia and one an *H. Influenza* bacteremia complicating nephrotic crises, both were treated with intravenous amino acids and recovered. It should be emphasized at this point that these nephrotic patients with bacteremia were treated with intravenous amino acids because their plasma amino acid concentration had dropped

below the critical level of 2.5 mg. per cent. Treatment was guided solely on the basis of chemical findings without regard to bacteriological reports. During a two-year period an aggregate of seventeen nephrotic crises complicated with a bacteremia have been treated and in great contrast to previous experience in this clinic not a single patient in this interval has died as the result of an *infectious* complication of a nephrotic crisis. It thus appears that inability to demonstrate a permanent rise in the plasma amino acid level with intravenous amino acids does not exclude the possibility of obtaining beneficial results.

These observations on the incidence and duration of hypoaminoacidemia in children with the nephrotic syndrome have reopened the question of the constancy of blood amino acid concentration in other disease states. Because of certain clinical similarities between the onset of recovery in pneumococcal pneumonia and that of children from nephrotic crises, as well as the prevalence of pneumococcal infections in nephrotic children, we believed that extension of studies on blood amino acids to diseases other than Bright's disease might profitably begin with pneumonia.

Farr, MacLeod, Fletcher, Emerson, Mirick and Curnen¹⁶ have found that in patients with pneumococcus pneumonia there was a significant plasma hypoaminoacidemia during the acute phase of the disease. The plasma amino acid nitrogen fell as low as 2.17 mg. per cent in one patient. During convalescence there was a gradual rise in the concentration of plasma amino acid nitrogen with a return to a normal level of 4.50 milligrams per 100 cc. on complete recovery from the disease. The striking hypoaminoacidemia shown by these pneumonia patients on admission to the Hospital and the rise in plasma amino acid nitrogen concentration to a normal value during convalescence have raised the question of using intravenous amino acids in the treatment of this disease. We have not as yet treated any pneumonia patients and only as the result of such experience can one state whether or not plasma hypoaminoacidemia in pneumonia is an indication for intravenous amino acid therapy.

Our studies on the incidence of hypoaminoacidemia are being extended to other acute in-

fectious diseases but again the question of indication for treatment must rest upon the result of future experience.

Hypoaminoacidemia is not limited to acute infectious diseases and the nephrotic syndrome. We have found it in a few individuals presumably suffering from metabolic disturbances, endocrine in origin. Until the significance of plasma hypoaminoacidemia is better understood, we do not believe treatment is indicated in these instances unless an acute disturbance, characteristic of that disease process, exacerbates the hypoaminoacidemia.

Specific contraindications for use of intravenous amino acids are not known. It is inadvisable to give these solutions to patients with decompensated cardiac disease when other intravenous fluids are contraindicated. In severe liver disease in which the liver failure has progressed to an extent which permits an increase in the plasma amino acids, it would appear unwise to further burden an already overworked liver. We have not observed any allergic type of reaction following its use. All patients report a sensation of warmth when casein hydrolysate is given intravenously. Patients in this clinic have almost uniformly developed a generalized skin flush during the infusion. We have had no febrile reactions. Shohl, Blackfan *et al.* have not noted the blushing reaction but have seen temperature elevations which they believe may be caused by the great specific dynamic action of the material. When the amino acids were injected too rapidly or in too great quantities our patients complained of sharp abdominal pain, usually localized in the right, upper quadrant. If injections were continued at this time emesis and retching usually followed. In our series of observations none of these minor reactions persisted after the infusion was discontinued. No changes in pulse rate or blood pressure have been observed which were significantly greater than were obtained with intravenous glucose.

Summary

The indications for considering treatment with intravenous amino acids may at present be placed in three categories, 1. *positive*, when the patient is unable to take anything by mouth and immediate improvement in his nutritional status is imperative, 2. *probable* when the

patient is severely malnourished, unable to take sufficient food by mouth and rapid improvement is necessary, and 3. *presumptive* when severe plasma hypoaminoacidemia can be demonstrated.

The known incidence of hypoaminoacidemia in disease states has been discussed.

Contraindications for intravenous amino acid therapy have been noted.

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FOREIGN MEDICAL JOURNALS

The *Journal* has received a communication from *La Prensa Medica Mexicana*, a magazine edited by the Clinic of Medical Attention for the Poor and published in the Mexican language. The editors are desirous of establishing an exchange with our *Journal*. If any of our members read Mexican and care to receive this magazine the exchange will be effected.

The *Journal* continues to receive a Ukrainian medical publication, strange as it may seem. Any one desiring this journal should notify this office at 54 Church Street, Hartford.

The Use and Abuse of Physical Agents in the Treatment of Chronic Arthritis*

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The problem of what to do with the chronic arthritic has tested the skill and ingenuity of practitioners of the healing art from the dawn of recorded history to the present time. No specific therapeutic agent has yet been discovered and no single method of treatment adaptable to all cases has yet been devised. Nevertheless, if our present knowledge and facilities are intelligently applied, much can be done for the relief of the chronic arthritic. Failure to accomplish the maximum in therapeutic results in the individual case can be largely attributed, first, to lack of coordination of medical effort and, second, to the economic inability of most patients to follow through an adequate course of treatment.

Therapeutics of Arthritis

The platform of sound therapeutics in arthritis is supported on four legs, represented by the internist, the orthopedist, the general practitioner, and the physical therapist, among whom close cooperation must be maintained. The province of the internist is to make a careful examination with particular reference to all contributing factors, to apply the newer methods of drug therapy as their value is proved, and to prescribe diet, regime, vaccines, etc., as indicated.

The orthopedist will correct posture, prescribe corrective exercises, take suitable measures for the prevention of deformities, and correct them as far as possible, once they have occurred. The physical therapist will make use of physical agents in an attempt to restore function in so far as possible, to relieve pain, and to improve the general constitutional background. The chief responsibility, however, must rest upon the

general practitioner, who must act as coordinator of the various specialists, and particularly must supervise the continuation of the patient's treatment at home. This necessitates maintaining the patient's interest and insisting that he follow out the regime for a long period of time. Perhaps one of the reasons why chronic arthritics do best in institutions or spas is due fully as much to this close cooperation of the various specialists concerned as it is to the apparatus which is used or the waters which they drink. Unfortunately, for economic reasons very few patients can spend a long time in a suitable institution, and even if they do so, much of the ground which they have there gained is lost because of failure to continue treatment at home. It is essential, therefore, that the general practitioner who accepts an arthritic case should have some knowledge of the methods of treatment as prescribed by the specialists and particularly of the methods which should be used as follow-up treatment in the patient's home.

Physiotherapy and Physical Medicine

Let me differentiate at the start between physiotherapy and physical medicine. Physiotherapy may be defined as including the physiological methods; such as massage, passive motion, exercise, and occupational therapy. These methods fall into the province of the physiotherapy technician, who is far better trained to exercise judgment in their use than are most physicians. Physical medicine, on the other hand, is the application of physics to medicine; and includes electricity, specialized forms of heat, light, and other forms of radiation, including X-ray. The application of these methods belongs in the field of the physicist or radiologist, or the physician especially trained in these subjects.

Very little good, if no harm, has been done by

*Read at The 15th Clinical Congress, Connecticut State Medical Society, New Haven, September, 19-21, 1939.

the indiscriminate use of diathermy and other forms of electrical energy by those whose sole training consists in what little they may have picked up from the instructions of a salesman of apparatus. With the far more powerful equipment now available, particularly in the field of ultra short wave, it is possible that harm can be done by those not properly qualified. We have only to consider what happened to the early workers in the field of X-ray before its dangers were known and guarded against.

Some of our orthopedic friends go so far as to claim that all that can be accomplished in the treatment of chronic arthritis can be accomplished by rest, hygiene, massage and corrective exercises; believing that there is nothing that can be accomplished by "complicated electrical apparatus" which cannot be done equally well by these simpler and less expensive means. With this viewpoint we must definitely take exception. It is true that the use of complicated and expensive forms of treatment, where simple measures will do just as well, does constitute one of the abuses of physical medicine; but it is also true that in many cases results can be obtained by diathermy, short wave, electrical stimulation or similar methods which cannot be obtained by the simple forms of heat, massage and exercise alone. In other instances results can be obtained in shorter time where the latter is supplemented by the former. Discrimination and experience is, therefore, essential. As a physicist and radiologist it is my purpose to limit this paper to the use of the physical agents, sometimes referred to as modalities, in the treatment of chronic arthritis, assuming that the concomitant methods of treatment will be carried out by others co-operating as above.

The office practice of physical medicine occupies a middle place between the institution and the general practitioner. The physical therapist can here follow up the work of the former and supplement that of the latter.

Omitting specific forms of arthritis, the majority of chronic cases will fall into the two main pathologic classifications of Nichols and Richardson¹, atrophic (rheumatoid or proliferative) and degenerative (hypertrophic or osteoarthritis).

In degenerative arthritis, since we cannot

restore the patient to his youth, we are forced to recognize the natural changes which have taken place and must adapt our therapy to meet these conditions, and relieve the affected joints as far as possible of further strain and trauma, while providing for such motion as may be possible within their limited range.

A. Use of Special Equipment in Institution and Specialist's Office

Physical measures are particularly adapted both for direct application to the affected joint or joints, and also for the general building up of the patient's resistance through constitutional measures. Heat, especially, has always been recommended as a preliminary to massage and exercise. Its value is unquestioned. Heat may be administered as ordinary baking, infra-red, luminous heat, diathermy, and short wave radiation. Other physical measures include ultra-violet, X-ray, hydro-therapy, and the low voltage electrical currents for iontophoresis and electrical stimulation.

In the specialist's office the ordinary baker is now largely used for extremities, and the large infra-red generators, or luminous heat from the 1000 to 1500 watt bulbs are used for the trunk. In some instances, however, small infra-red or lamp units are used for the extremities, perhaps because they are less cumbersome, but it is doubtful if they are as effective. Mild heat produces vasodilatation, relaxation, and sedation. With infra-red and luminous heat, the effect is largely peripheral.

Diathermy

With diathermy, on the other hand, there is a deeper heating effect, resulting in an active hyperemia in areas of passive congestion and exudation. It has been claimed by some³ that diathermy increases the demineralization of calcium in the areas treated, and that, therefore, its use in rheumatoid arthritis is contra-indicated. Conversely, diathermy has proved to increase the laying down of new bone in cases of fracture⁴. It would appear, however, that the action of diathermy in decreasing the decalcification in already affected joints such as are usually found in rheumatoid arthritis is not per se a specific action of the diathermy current on the bone at the site of the lesion; but rather a stimulation of circulation and metabolism, there-

by increasing a process which has its origin elsewhere in the body. We do not believe that diathermy is contra-indicated in rheumatoid arthritis if attention is paid to correcting systematically the defective calcium metabolism. In fact, it has been our experience that in sub-acute and chronic joints of both the rheumatoid and degenerative types, many patients will state that they have obtained relief from diathermy where infra-red and luminous heat have failed. On the other hand, diathermy is definitely contra-indicated in acute inflammatory conditions because apparently it increases the hyperemia in an already congested part, and thereby increases the pain. In an acute bursitis or painful shoulders, for example, diathermy, as usually administered, almost always aggravates the symptoms, whereas mild heat, such as infra-red or luminous heat, often gives relief. The method of applying the diathermy has a definite bearing on the success of the treatment. Through and through diathermy apparently gives a deeper heat effect, and the double cuff method gives a more diffused superficial heating. In general, a lower intensity for a longer time gives better clinical results in most cases. Diathermy should be gradually turned on at the start of the treatment to avoid stimulation of vascular spasm.

"Short Wave" Diathermy

Recently conventional diathermy has largely been replaced by so-called "short wave diathermy", partly because of greater convenience in application and partly because greater depth of heat penetration is obtained. Experiments have shown that with diathermy the greater part of the heat effect takes place in the skin and superficial tissues and is not a true through and through heating⁵. The bulk of the current apparently follows the path of least resistance which usually is around the joint rather than through it. With short wave, heat generation is either by electromagnetic or electrostatic inductance. The former makes use of an induction coil or cable wound around the part to be treated or laid upon it as a pancake coil. Heat generation is more diffuse and more superficial. There is a marked peripheral vasodilation. With electrostatic inductance, there is a more uniform heating of the deeper structures in relation to the overlying superficial tissues. The efficiency of this

depth heating is a function of the wave length, the spacing of the electrodes, and the output capacity of the apparatus. The shorter the wave length and the greater the spacing of the electrodes the more uniform is the depth heating.

In this country wave lengths of 12 to 16 meters are commonly used for superficial heating and the so-called ultra short waves of six meters or less are used for deep heating. Spacing of more than an inch or two, however, requires more output capacity than is available in most apparatus. While wave length plays an important part in the efficiency and uniformity of depth heating, there is no positive evidence available at this time to indicate that there is any therapeutic specificity of wave length as has been suggested by Schliepake and others⁶. Selective action of electrolytes in picking up radiation by electrostatic inductance does, however, undoubtedly account for the greater heating of bone in comparison with soft tissues. With electro-magnetic induction, however, the greatest heat is in the fat and sub-cutaneous tissues.

There is considerable reason to believe that "deep heat" is not what we want, especially in rheumatoid arthritis. If the primary consideration is here to increase the peripheral circulation and to stimulate local metabolism, it would seem that better results could be obtained by the longer wave lengths, and particularly when used with electro-magnetic induction. There is, furthermore, a theoretical danger of over-heating the bone or cartilage by too intensive "deep heat" without the knowledge of the patient or operator, since the circulation and nerve supply here is poor. It is possible that such damage to the cartilage might not become evident for some time and might then be attributed to other causes or to a further progress of the disease.

In my experience six meter short wave, if not overdone, gives its best results in degenerative arthritis, using the electrostatic method. The electro-magnetic method at 12 to 24 meters usually works out best in the rheumatoid forms. It should be noted that over-dosage with the six meter radiation is not evidenced by heat, but rather as dull ache or pain. Therefore; if either form of treatment causes increased pain, the intensity, the time, or both should be cut down.

Recently I have been experimenting with unipolar diffuse radiation at six meters. The indifferent electrode is partially grounded by placing it on the floor. I have found this method particularly adapted to the hands and feet. With proper positioning and spacing, the heat can be concentrated in the finger tips, palm or wrist at will. The heating appears to be uniform and without the complications and reactions sometimes experienced with the usual bipolar through and through or parallel plate methods.

There is some evidence to suggest that the therapeutic results from short wave are not due to heat alone, but rather to an athermic vasodilation which may persist for some time and is uninfluenced by adrenalin. Changes in cellular metabolism and osmotic exchange are also suggested by experimental work done chiefly abroad, but not yet confirmed in this country⁶. On the whole, we believe that the role of short wave therapy in arthritis has been undervalued, and that it will become increasingly used as its rationale is better understood and its technic is perfected.

Electrical Stimulation

Electrical stimulation by low voltage currents is of very little value in the treatment of rheumatoid arthritis. They are chiefly used for their tonic effect on atrophied muscles, chiefly in bedridden cases. Their action is more that of massage than of exercise. Pemberton and Cajori⁷ have shown that muscular contractions stimulated by electrical currents do not produce lactic acid as is the case with muscles voluntarily exercised. Therefore, electrical stimulation cannot be used as a substitute for exercise as an aid in sugar removal. Iontophoresis with the galvanic current, using vaso-dilator drugs, produces a peripheral vaso-dilation and a sensation of heat which lasts for some time⁸. The technic is somewhat more time consuming and less effective than short wave. Probably as good results can be obtained with the paraffin baths as elsewhere described.

X-ray Therapy

There is considerable evidence to indicate that x-ray therapy may be of considerable value in the treatment of arthritis, both local and general, although there is some difference of opinion as to just when and how it should be applied. Her-

naman-Johnson states that "X-rays⁹ are of great value in hypertrophic, non-infective osteoarthritis, are worth while trying in chronic infective types, and may give local and temporary relief in the rheumatoid forms, but are probably valueless in the true degenerative arthritis in the very old."

The best clinical results are apparently obtained in painful actively infected joints¹⁰ in which relief of pain is probably due in part to the analgesic effect of the X-ray on the nerve endings and in part to the reduction of the inflammation by the action of the rays on the leucocytes in the exudate. Newly formed tissue is more susceptible to X-ray. It is possible, therefore, that there may also be an inhibitory action of the rays on synovial proliferations and pannus.

Rohr¹¹ has obtained good results in both types when other methods have failed. He states that pain and swelling are reduced, creaking lessened, and range of motion improved. Fried¹² states that results in gonorrheal arthritis are striking, one treatment of 120 r often being sufficient to effect a clinical cure.

The severe reactions mentioned by Pemberton¹³ may be avoided if the initial doses are fractionated.

Acute exacerbations in rheumatoid arthritis may occur as a result of exposure, cold, intercurrent infections, etc. and require special handling. Such joints may be swollen and extremely painful. Krusen¹⁴ states that heat in acute joints is not contra-indicated. Mild sedative infra-red and luminous heat may help. Conventional diathermy and short wave, however, are here contra-indicated.

Indirect Diathermy

Indirect diathermy often gives surprising relief. The technic is to place the patient on an auto condensation pad connected to the Oudin terminal of a high frequency machine and to withdraw the current through the operator's fingers moving gently over all parts of the joint. Treatments should last at least 20 minutes and may be repeated daily if necessary. Leece¹⁵ stresses the value of this treatment which he believes deserves to be more widely used. In lieu of an auto-condensation pad any treatment table can be made to serve by placing on

its top a sheet of galvanized iron at least two or three inches smaller, and connecting it to the ground. On top of this as a dielectric is placed three or four thicknesses of blanket or a thin mattress, depending on the capacity of the machine. The patient is then placed on top of the blanket or mattress. Wolf¹⁶, in his textbook of Physical Therapy, states that the ideal treatment for acute joint conditions is the appliance of iced compresses, claiming that they reduce the inflammatory process and the edema, relieve the pain, and greatly shorten the course of the disease. In my own work, I have been very well satisfied with the results obtained by using 80 to 125 R units of X-ray, one treatment very often showing a marked relief.

Thus far we have discussed the use of physical agents applied directly to the involved joint or joints as used in the institution or in the specialist's office. Heat, hydrotherapy, ultraviolet, X-ray, and climate are also made use of to build up the patient's resistance and to improve his neurocirculatory disfunction.

Mild elevation of the body temperature by steam baths, cabinet baths, solaria, mud packs, etc., are routine procedures in most institutions and spas. There is no question that mild heat does increase the patient's sense of well being, increases his resistance to infection, and improves his circulation. It is particularly valuable to induce relaxation as a prelude to manipulation and massage. Too vigorous or too prolonged applications, particularly in the case of individuals who are none too robust, may result in prostration and further lowering of the patient's recuperative powers.

Fever Therapy

Fever therapy has been found to be almost a specific in the treatment of gonorrheal arthritis, but its value in acute, non-specific forms is still not fully determined. Fever therapy, however, is a very strenuous method of treatment, requiring as it does long hours in a fever cabinet, at a comparatively high temperature. Its use therefore, must be limited to patients of a fairly rugged constitution. Equally good results in gonorrheal arthritis of the knee can be obtained by a local six meter short wave radiation and by X-ray without any risk to the patient, although it must be admitted that any residual infection in the primary focus is not thereby

cleaned up. It now seems, however, that fully as good results can be obtained with equal promptness by the use of some of the newer sulphanilamide preparations.

Krusen¹⁷ recommends daily fever therapy of short duration (thirty minutes) as a valuable adjunct in routine physical treatment of arthritis, preceding massage and exercise. In my experience the effect of a mild fever therapy in the infectious and rheumatoid types can be equally well obtained by ultra short wave radiation over the spinal nerve roots. This, if carried to extreme, may produce excessive perspiration and possibly an occasional mild heat reaction, but nothing so severe as in most cases following the fever cabinet method.

Hydrotherapy

Hydrotherapy is largely an institutional procedure, the various forms of which have been described elsewhere. The metabolic stimulation of contrast baths, the Scotch douche, and the sedative and thermal effect of tub baths, whirlpool baths, etc., are well established. Modifications of appliances and technique suitable for office use and use in the home have been described by the Council of Physical Therapy and will be briefly referred to below.

The value of underwater exercise in a Hubbard or similar tank should also be mentioned. Saline baths, particularly Epsom salts, have their value.

Colonic Irrigation

Colonic irrigation has been much discussed. It may be indicated in certain selected cases. There is no question, however, but what this form of therapy has been much overdone, and in some instances a constipation which could be easily remedied by proper treatment has, by too much colonic irrigation, resulted in an irritable colon or colitis, much more difficult to control; to say nothing of hemorrhoids and similar discomforts which too often are also sequelae. There is reason to believe that the sense of well-being following colonic irrigation is not, in fact, due to elimination of toxins (the result is much too prompt), but rather to a circulatory readjustment following relief of the over-loaded bowel. The normal bowel mucosa does not absorb toxins. Whether there is a breaking down of this protective function in arthritis is still controversial.

Electrical Muscle Stimulation

Electrical stimulation of the abdominal musculature by the Morse wave or similar low frequency currents has also been advocated for the treatment of constipation associated with arthritis. One can obtain a fairly vigorous contraction of the abdominal muscles by this method, but Reynolds¹⁸ has proved by means of fluoroscopic examination during such treatment that there is no direct stimulation of gastric or intestinal peristalsis. It would seem, therefore, that the use of this method is a lazy man's way of exercising his abdominal muscles. It might conceivably be indicated for a bedridden patient, but there is reason to doubt even here if it is as effective as deep abdominal massage over the colon.

Ultraviolet Rays

There is no specific indication for ultraviolet in degenerative arthritis¹⁹, except as one of the "general supporting measures". Its use in the aged is held by many authors to be contraindicated²⁰. In rheumatoid arthritis, however, it is of definite value in aiding to build up the patient's general resistance to toxins and infections. Circulation is improved, hemoglobin and red blood cells are increased. The discomfort of cold, clammy hands and feet disappears²¹. Ultraviolet is especially indicated where there is asthenia or secondary anemia²². In marked asthenics or deliberated patients, however, it should be used with extreme caution in order to avoid systemic reactions, which under these conditions can be quite severe. For office and sanitarium use the quartz mercury or carbon arc lamps are commonly used. When sunlight is not available, the G.E. S-1 bulb is recommended for use in the home. It is said to be the equivalent of June noonday sunlight. The technique described by Rollier²³ or a modification adapted to individual conditions should always be used until the patient's reaction has been determined. Treatment is started with a small area exposed for a short time; then gradually increasing the exposed area in the time until a faint erythema is obtained. The combination of general body radiation by infra-red or luminous heat with ultraviolet is very gratefully received by rheumatoid arthritis.

Indirect X-ray Therapy

Various authors abroad and Langer²⁴ in this

country have noted the clinical improvement following "indirect X-ray therapy" where the rays are applied paravertebrally over the spinal nerve roots rather than directly to the affected joint or joints. The action of the rays is through their effects on the sympathetic nervous system and thereby indirectly on the involved joints. Langer states that such radiation produces better tissue metabolism and better blood supply in the affected area through changes produced in the sympathetic tone. In some respects this action is similar to an anaphylactic reaction, and in addition there is a marked analgesic effect. Since most rheumatoid arthritics present evidence of neuro-circulatory instability with impairment of the sympathetic tonus, it would seem that we have here a new method of therapeutic approach which has possibilities warranting further study.

Climatic Effects

The favorable influence of a high dry climate on rheumatoid arthritis is well known. From the work of Yaglou²⁵ at the Harvard School of Public Health it would appear that this effect of climate may in large part be a function of the concentration and ratio of the positive and negative ions in the atmospheric air. Counts by means of an ionometer have shown that atmospheric ionization is much higher on clear, sunny days than on foggy and gray days; in summer than in winter; and in daytime than at night.

Quoting the work of Dessauer, Yaglou states that positive ions increase the respiration rate, the metabolism rate, and the blood pressure; whereas negative ions decrease these functions, Inhalation of positive ions resulted in headaches, dizziness, nausea, a sense of fatigue, and, in some cases, irritation of the nose and throat.

Inhalation of negative ions produced a cooling effect on the body, especially in summer, and a sense of relaxation and sleepiness.

It is interesting to note that arthritics are at their worst on dark, damp days. They often complain of rheumatic twinges just before rain or thunder storms, at which time there is an abundance of positive ions in the atmosphere.

With modern advances in air-conditioning, it may well be possible to duplicate the favorable climatic conditions of Arizona in the arthritic's home.

* B. Home Treatment

Krusen in his book on "Physical Therapy in Arthritis"²⁶ and in numerous papers has stressed the importance of home treatment for arthritics, making use of simple measures and home made apparatus.

Specifications for most of the apparatus here described can be obtained upon request to the Council of Physical Therapy of the American Medical Association.

The fundamentals of home treatment, in addition to exercise and massage, are based upon the intelligent use of heat and cold. Small infra-red units or heat lamps can be bought at almost any drug store. While they do give off enough heat to provide a comfortable feeling of warmth, most of them are not efficient enough to be of much therapeutic value. A very simple electric baker which can be made by any tinsmith for a small sum is described by the Council of Physical Therapy. It consists of a hood of sheet tin under which are mounted four 60 watt bulbs. This has proved very satisfactory for the extremities.

Another very satisfactory and efficient method of applying heat is the paraffin bath. This method is used extensively abroad but has not received the attention it deserves in this country. Five or six pounds of paraffin are purchased at the grocery store. This is melted in an ordinary double boiler. It is then allowed to cool until a scum appears. It can then be applied to the affected joints by a paint brush to a thickness of six or eight layers. If support is required, layers of gauze can be added, forming a temporary splint.

In the case of the fingers or toes, simple repeated dipping will accomplish the same purpose. Hair, of course, should be removed by shaving. Rarely one will encounter a patient who is sensitive to paraffin, in which case a mild dermatitis will develop.

Reference has been made to the use of infra-red or luminous heat in the treatment of painful, swollen joints. The effect will be augmented by the use of hot, wet gauze packs which can be wrapped around the joint and kept hot by the lamp.

Epsom salt solution have been recommended as a wet dressing. For acutely inflamed joints

cold packs as advocated by Wolf (*vide infra*) are well worth trying.

Contrast baths for the hands or feet are quickly made available by the use of two buckets one of which contains hot water (105-110°F) and the other cold water (60-65°F). The extremity is immersed in the hot water for five or six minutes and then in the cold for two or three minutes; immersions being repeated four or five times at a sitting.

For the knee, the patient can sit on a stool with the leg and knee over the edge of the bath tub and alternate hot and cold douches can be applied by means of two pitchers or a shower bath spray. The spray can also be used for the back and shoulders. Whirlpool baths can be constructed at home using a wash boiler and a few plumber's fittings (specifications from Council of Physical Therapy). The aerated hot water is circulated at a temperature of 110°F. It produces peripheral vaso-dilations, relaxation, and sedation.

General Physical Therapeutic measures for home use include improvised steam cabinets, hot tub baths, contrast showers, wet packs and sun baths.

A home-made steam cabinet can readily be improvised by draping sheets over a couch by means of a skeleton frame and providing steam by kettles heated by electric stove units on the floor below.

Hot tub baths are especially recommended for rheumatoid arthritics. Cecil's²⁷ technic is as follows:

"The tub is filled with hot water at a temperature of about 100°F. The patient gets in the bath, and the temperature is gradually raised to 104°F. The bath is maintained at this temperature by means of a bath thermometer, and the patient remains in the bath submerged up to the neck for from thirty to forty-five minutes. A cold towel can be applied to the forehead to lessen the discomfort. The patient should then be sponged off with cold water or alcohol and go to bed. This bath should be taken on an empty stomach. The patient can take some food, preferably liquids, after the bath is over." There is no question but what these hot baths give considerable, although temporary, relief.

Rheumatoid arthritics are particularly sen-

sitive to thermal changes, particularly to cold. In most cases the body can be "hardened" to thermal changes by the judicious use of contrast shower baths. A warm shower is followed by a dash of cold and then by a brisk rubdown. The patient normally should react with a warm glow. If the patient remains chilly the time or temperature range should be cut down.

The full wet pack described by Coulter²⁸ is an effective method of providing warmth and sedation. The patient is wrapped in wet sheets of 60 to 70° and fully covered. Following an initial chilliness, there is a marked vaso-dilation, and the patient becomes comfortably warm and sleepy.

Exposure to sun and air in suitable weather on a sheltered porch can be very helpful. In cold weather the patient can be exposed to infra red radiation adjacent to a closed window; the ultra-violet rays are cut off by the glass, but the infra-red which passes through the glass will provide a very effective baking.

Conclusions

Chronic arthritis must be regarded as a systemic disease having local manifestations in the joints. Etiologically there are both predisposing and precipitating factors to be considered. Treatment, therefore, must be directed both to the constitutional and to the local conditions. It necessitates the cooperation of the internist, orthopedist, physical therapist, and general practitioner. It should preferably be started in an institution or adequately equipped office, closely coordinated, and followed up by continued treatment in the home.

Specialized forms of heat, such as diathermy or short wave, electricity, and radiation, including ultraviolet and X-ray, can hasten the patient's recovery in some instances and in others can definitely obtain results which cannot be obtained by massage, exercise and the simple forms of heat alone.

The abuse of physical agents consists in the over use of such expensive and complicated forms of treatment in those cases where the simpler methods could prove adequate, and particularly in the tendency on the part of some physical therapists to depend too much on the use of their apparatus to the neglect of the simpler methods which can be carried on with minimum expense under the direction of the general practitioner in the patient's home.

Massage, exercise, and occupational therapy have not been included as a part of this paper. It should be definitely understood that they play a most important part in the treatment of arthritis, and must be carried on simultaneously with the use of the physical agents herein discussed. Finally, I trust that I have demonstrated that a great deal can be done for the chronic arthritic who for economic or other reasons must carry on most, if not all, of his treatment at home.

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Progress in Preparedness*

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The medical services of the Army and Navy asked the American Medical Association at its annual meeting this year, to put the great resources of its organization at the disposal of the government as part of the national preparedness program. This request from these all-important government services coming at a time when another department of the government was seeking to discredit medicine through the courts, created an interesting paradox.

During the months since June, the American Medical Association has done its best to organize the medical profession for military service. The response to this effort has been somewhat uneven in various parts of the country and although there is no gauge by which the temperature of enthusiasm may be measured, it is not to be denied that the interest in national preparedness varies widely among individuals even if they cannot be geographically defined. On October 10th, the chaste pillar of erudition that reflects New England medical thought, the New England Journal of Medicine, stated editorially, —“ . . . and yet with all this talk and activity one can sense beneath the surface a feeling of unreality; as if we truly believed it all to be an uncomfortable dream from which we shall awaken to plod along again in our comfortable middle class fashion. . . .”

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all to be an uncomfortable dream from which we shall awaken to plod along again in our comfortable middle class fashion . . .”

The profession of medicine in America is conservative in its philosophy and practice. It is generally and voluntarily isolated from and relatively indifferent to political change and economic disturbance. The feeling of uncertainty that we now sense beneath the surface “is an uncomfortable dream that is premonitory of an upheaval of such proportions, psychic, political and economic, as this nation has not known within the memory of any living person. For medicine it may be premonitory of the end of an era of dreams, of self-praise, of complacency.” says the New York State Journal of Medicine.

Meanwhile as these things go on about us a program of useful effort is slowly developing. Some of the program is conceived in hysteria, some of it will be trivial and inadequate if it is called upon to work, and some things are being done because of the tonic effect they have on the doers rather than for any practical accomplishment. The tangible things are not difficult to approach. Medicine is first concerned with obtaining and furnishing personnel for the armed forces, passing upon the qualifications of soldiers and giving men trained in medicine to the Army. This is a relatively simple thing to do. Other things are not so clearly defined or so apparently necessary.

There are communities whose plans for evacuation have already been worked out and means for the protection of civilians have been contemplated, and who is to say that such things are fantastic? Closer within the realm of reality comes the serious consideration of the help that medicine must be to industry and the development of simple workable plans for relief in diasters such as might result from accident or design in war time industry.

The organization that is concerned with the

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medical part of the preparedness program is headed by a national committee that was appointed in June by the House of Delegates of the American Medical Association. Doctor Stanley Osborn, the Health Commissioner of Connecticut, is a member of that committee. In each state there is a state chairman on medical preparedness. Here, Doctor George Smith of Pine Orchard occupies that office. Doctor Smith is assisted by a county chairman on medical preparedness in each of our eight counties.

A civilian preparedness organization in the State has been set up by the Governor. It consists of State officials and is under the direction of General Sanford H. Wadhams who, is a retired Medical Officer of the U. S. Army. General Wadhams is serving on the State Defense Council as an administrator and not as a physician. The only physician on the Council is the Health Commissioner. The Governor has asked for the organization of local committees on preparedness in the several cities and towns of the State. These local committees have been appointed by the mayor or the first selectman and physicians are serving on many of them. The activities of these local committees are still rather vague and the preparedness organization in the State Medical Society has made productive contact with but two of them, in the City of New Haven and in Waterbury.

In the national government itself, there is a committee on Medicine and Health which is a sub-committee of the Council of National Defense. The Committee on Medicine and Health is under the chairmanship of Doctor Irvin Abell and others on it are the Surgeons General of the Army, Navy and Public Health Service and Doctor Louis Weed of Baltimore representing the National Research Council.

Under this Committee on Medicine and Health are a number of sub-committees which have to do with the several functions of the Committee. There is a sub-committee on Medical Education of which Doctor Burwell, Dean of the Harvard Medical School, is chairman; a sub-committee on Hospitals of which Doctor Winford Smith of the Johns Hopkins Hospital is the chairman, other members being The Rev. Alphonse Schwatalla, Doctor Mal-

colm MacEachern, Doctor Claude Munger and Doctor Nathaniel Faxon of the Massachusetts General Hospital; a sub-committee on Industrial Medicine under the chairmanship of Doctor Clarence Selby, Medical Director of General Motors Corporation, and serving on that Committee is Doctor George Smith, the Connecticut State Chairman, who is the Medical Director of the Scoville Manufacturing Company, Waterbury. There are also sub-committees on Dentistry, Nursing and Negro Health.

Insofar as medicine is concerned, for the present about 8000 additional physicians will be needed for service with the armed forces. To supply them need not be difficult and no community need be stripped of necessary medical service if care is exercised in the selection of these physicians. It appears that the health and medical care of industrial workers, their families and the communities in which they are employed and the communities near which military forces are assembled, present a greater problem than the medical needs of the military forces themselves, and the hospitals' place in this pattern is important.

Stimulated by these emergency conditions it is hoped that we may come to a clearer realization of our community needs in health. It is probable that those needs lie somewhere between the fanciful claims of governmental bureaus and those of some of our own complacent spokesmen in medicine, and perhaps just ahead lies the opportunity to make an accurate appraisal of actual local needs in each area and to develop a sound program of assistance based on the utilization of existing resources and the creation of new facilities and personnel where necessary to insure a reasonably adequate health service for everyone.

Hospitals will be basically concerned with the importance of continued operation at maximum efficiency in order to care for the civilian population and to serve the public health in case of large scale disaster, and all of this in the face of possible withdrawal of trained personnel.

Specific plans are being considered whereby careful inventory of the existing bed vacancies will always be available. In the cities in this State, the number of vacant beds appear to be

insufficient to meet any emergency overload and it seems essential for our hospitals to consider means for rapid expansion to meet emergency conditions.

I am informed that a regional index listing extra beds that would be available to the government in time of emergency has been undertaken by the American Hospital Association.

Our hospitals will be called upon to provide and train all kinds of personnel for the military services, and as their own technical people are withdrawn for military service, they will be faced with the necessity of training others to take their places within their own institutions.

There is some likelihood that, as time goes on, complete units such as base hospitals, evacuation hospitals and mobile units may be asked for from civilian hospitals. So far there have been but a few such requests and, indeed, at present patriotically minded institutions have occasionally felt that their offers of such organizations have been received rather coolly. It must be borne in mind that perhaps first things are coming first and that there will be no actual need for these units until later on. Anyone who went through the organization of these things during the last war fully realizes the importance of strong leadership and tactful selection.

The status of hospital employees under the Selective Service draft is often asked. I am familiar with the requirements of the Selective Service Law and the provision for exemption therein and have sought information on just this point from many sources. No categorical answer may be given. It seems to be the intent of the National Selective Service Board to defer draftees who are graduates in medicine until they have completed at least one year of interne service. The underlying reason for this is that a year of internship is required before a physician is eligible for a commission in the medical corps of the Army or Navy. In some instances we are told that deferment will be allowed to complete a second year of hospital training. Just what the circumstances must be is not made clear. Decision with regard to deferment or exemption lies entirely within the local draft board where the enrollee is registered. In the event that a decision re-

garding deferment or exemption by this Board is unsatisfactory, appeal may be taken to the Appeal Board by the enrollee himself or his employer. Already some conversations have been had concerning the deferment and exemption of hospital internes and it is hoped that the State Medical Society may be of some service in seeing that the boards concerned have a clear understanding of the cases as they may arise and while it is obvious that no definite statement may be made in this respect, I would like to assure your organization of our help for whatever it may be worth.

Now to remove ourselves from these real things that surely surround us we may think for a little while about some others that cannot be so clearly contemplated. A few months ago there was some information to the effect that the government would hand down directions for organizing community programs to go into operation in the event of catastrophe or attack. Very lately we have learned that such plans will not be forthcoming and that each community may direct its attention to its own problems as it chooses and set down such plans as seem wise to it. This has already been done in some localities. Here in Connecticut our State Committee has been working on what we have rather grandly called a model plan for a city. It is based upon experience and information from some of the European cities and London that has been made available to us.

One of the things that has impressed us as our familiarity with foreign experience has increased is the emphasis that is laid on decentralization of facilities.

Under the plan that we are developing, a city is divided into zones. The size of each zone is determined by its density of population and number of industrial plants. Within each of these zones there should be a complete disaster unit consisting of 1. a centrally located headquarters having necessary supplies and space sufficient to serve as a dispensary for ambulatory cases, 2. a number of emergency sub stations conveniently situated to possible points of disturbance, 3. one or more physicians and nurses who are residents of the zone will be designated as district officers, 4. a list of physicians within the zone whose services would not be required in hospitals, 5. a list of public

duty nurses, that is visiting nurses, public health and Red Cross nurses, living within the zone, 6. a list of volunteer laymen to act as stretcher bearers in the case of emergency. It is proposed that this activity may be organized by the American Legion or some similar group, 7. a list of commercial and privately owned vehicles that would be ready for any emergency.

In the event of a catastrophe a signal would be given warning all citizens and designating the zone that was involved. On hearing this signal, each member of the personnel in the involved zone would report immediately to his own headquarters and from this headquarters be directed to the scene of the accident. At the same time, personnel at other zones are to assemble at their headquarters and await further instruction or until the situation is under control. It is thought that such a plan should prove of sufficient elasticity to accommodate all forms of emergency such as conflagration and explosion.

The zone headquarters should be properly publicized so that it will become known to every individual residing within the zone. In periods of emergency it could serve as a public dispensary and during such periods should be manned at all times. Personnel attached to these headquarters will require instruction in their duties. In selecting personnel it is felt that the local health officer would be put in charge of the medical division and some, at least, of his subordinates should have had previous military experience in order that they might have a better understanding of this type of organization.

So far we have not definitely considered the hospitals' part in this plan. Obviously casualties removed from the scene of the disaster would be delivered to hospitals and those who are developing these community organizations are looking forward to the time when they may consider with hospital executives the part that hospitals will take. All of our hospitals are smoothly functioning units and it is felt that the consideration of the problem that will be necessary from them will be readily forthcoming. Two points have impressed us with respect to the hospitalization of patients. First, means should be provided for sorting the

patients immediately upon their arrival at the hospital so that no time will be lost in getting a patient to the proper department or physician for the special care that he may require, and, second, establishment of a workable means to provide beds to meet the uneven demand. In some instances it has been recommended that this be provided for by maintaining a fixed vacancy of beds in order to meet emergencies. Such a plan seems hardly advisable here for, of course, we need the beds for other purposes. Another suggestion that is to maintain a daily census of those patients who might be evacuated from the hospital quickly, sent to their homes or other places so that their beds might be available for disaster victims. A third suggestion, which in some instances may be the most practical, is to provide an emergency ward in accommodations that are at present not being used.

In those communities where the zone method for emergency relief, such as is outlined above, may not be practical, and in smaller communities, another plan has been devised.

This plan relies upon a catastrophe squad that is organized in a hospital. It is the method that has been adopted in the hospitals of the city of New York, and, strangely enough, seems to answer the needs of some of our small communities.

The organization consists of a group of graduate nurses, twelve more or less, with one nurse the captain and a varying number of physicians either from the resident staff of the hospital or from the junior members of the attending staff who would always be available. Transportation is provided for this unit with an emergency ambulance and an ambulance bus. The emergency ambulance serves to transport those who need hospitalization from the scene of the disaster to the hospital and the bus is used to carry the personnel of the squad and its equipment.

The equipment is packed in two large wooden boxes containing drums of sterile supplies and medication (instruments, gauze, bandages, iodine, alcohol, etc.) and another box which contains splints and bandages necessary for the emergency mobilization of fractures. Further equipment includes syringes, tetanus antitoxin and two canvas bags containing blankets which

may be spread on the ground. In this pattern of organization the nurses and doctors are grouped into teams each under a chief. The nurse in charge of the emergency ward in the hospital to which the unit is attached has the responsibility of seeing that the boxes are always supplied and ready for immediate use. She will check everything upon return from a call and be made responsible for the preparation and sterilization of equipment. Such a squad would respond to any necessary call occurring in the locality of its establishment and a number of them might be called to aid squads in their neighboring locality in the event of a major catastrophe.

Disasters have already occurred in some other states, disasters where the casualty lists have been heavy. Connecticut is widely involved in the production of the munitions of war and exposed to sabotage and accident. Only the dullest among us will think that "it can't happen here."

Still further away from reality comes the speculation about attack and invasion. Happily it seems very remote but I have taken part in two semi official conferences that were concerned with the evacuation of civilians and the establishment of hospital facilities in the event the present establishments were demolished or become ineffective. This quiet peace-loving State is in a vulnerable spot, already classified as a target area. It is a circumstance that has to be thought about.

I have tried to tell you of the preparedness program as it now stands. You will at once realize that it has not progressed very far. Whatever has been done has come about through local initiative. Except for medicine's participation in the selective service procedure no directive has been received from the government. Perhaps you share with me a consciousness of an indifference toward the whole project on the part of your colleagues and mine. Maybe it is to be expected. We are not at war in spite of some of the inflammatory utterances that we hear. Perhaps medicine has been too slow to realize the gravity of the situation, but I am willing to hazard a guess that when our services are actually needed we shall not be found wanting. Some blunders will be made that cannot be helped, for in general physicians are not built

right to make good soldiers and if some way could be devised so that they could soldier less and doctor more in the army, it would be to everyone's advantage. Military service has a strange effect on most physicians and causes them to suffer from what another has lately called a "cactus complex," which he says "is a bristling thorny untouchability usually accompanied by several stigmas, small shoe brush mustaches, grape-like pendulous tumors dangling from the left wrist and a dermatosis resembling a small watch hidden by the cuff." All these are intermittent sources of irritation producing sudden jerky movements, usually crooking of the elbow and frequent nervous inspection of the wrist to see what time it is for no reason at all. Our usually mild and quiet colleagues, as soon as they put on a uniform, will develop the idea that to be consistent they must develop a certain fierceness and barking speech and heel clicking smartness. A brief course in deportment is suggested while there is yet time. I submit too that tailors should be more carefully controlled. There is something comfortable and confidence inspiring in a family physician whose bedside raiment is characterized by a wholesome indifference, but this same man, distorted, compressed and caused to bulge in a uniform that has been designed and sewed under the influence of war hysteria, cuts a figure that is bad for the morale of the old regiment.

You will pardon this note of levity. Perhaps I should not have allowed it to creep in for I do not hold the present circumstance lightly. Neither do I think that it is altogether indifference that holds us back; rather I think it is a reluctance to accept the philosophy of war. Just a year ago at the beginning of the war in Europe, I had the temerity to analyze this reluctance in an editorial in the Connecticut State Medical Journal. It is short and I ask permission to read it to you again because I think it answers many things.

"Physicians look at war with fine abstraction; they are essentially men of peace, with a high sense of moral values deeply rooted in an inherent charity and simple integrity. By training and temperament the man of medicine is

(Concluded on Page 67)

Simultaneous Occurrence of Herpes Zoster and Varicella

With Report of Two Cases

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Since Bokay, in 1888, first called attention to the relationship between herpes zoster and chicken pox, many instances have been reported in which chicken pox developed in susceptible persons exposed to herpes zoster and vice versa. Evidence in favor of a relationship between the two diseases has been massed by numerous investigators. Such evidence includes: (a), Pathologic skin lesions of the two diseases are very similar — clinically, macroscopically, and microscopically¹; (b) Paschen² found similar elementary bodies in the vesicles of both diseases, which was confirmed by Amies⁷ (c) Emulsions of the lesions of each disease produces the same kind of pathologic changes when injected into the testes of monkeys³; (d) Susceptible persons inoculated with the contents of the herpes zoster lesion developed 'takes' which protected them against subsequent exposure to chicken pox⁴; (e) Both Bruusgaard¹ and Kundratitz⁵ produced chicken pox by inoculating children with vesicle fluid from cases of herpes. Children who had had varicella did not react; (f) Complement-fixation tests with the blood serum from patients with chicken pox and the virus of herpes lesions were positive, and so were the tests with the serum from herpes patients and the virus from chicken pox lesions⁶. This has been confirmed by Amies⁷; (g) The somatic localization of the two diseases is identical. In a series of 46 zoster cases, Stern⁸ projected the lesions on one body diagram, and the result showed that the parts involved in order of frequency were the trunk, then the face and head, and

least the limbs, with none on the palms and soles. This is also the distribution of the varicella lesions.

So strong is the evidence in favor of a relationship between these two diseases, that Stern⁸ concludes that they are the same infection, and Downing⁹ feels strongly that it is dangerous to expose a patient who has not had chicken pox to a case of herpes.

On the other hand, there is evidence against such a close relationship between these two diseases. (a) There is a marked difference in age and seasonal distribution¹⁰. Varicella is a disease of childhood, herpes of adults. The incidence of chicken pox fluctuates thruout the year, that of herpes remains more constant. (b) Many adults who have an attack of herpes have a history of chicken pox in childhood, which should have conferred immunity to herpes were the two diseases identical. (c) Chicken pox virus, which usually will produce certain tissue changes when injected into experimental animals, fails to do so when recent convalescent chicken pox serum is added to it; but the virus is not affected by the addition of blood serum from recently convalescent herpes zoster patients¹¹.

Considering a somewhat different phase of the same problem, namely, the simultaneous occurrence of herpes zoster and varicella in the same patient, there are much fewer cases reported. Ferriman¹², in a comprehensive review of the literature, mentions 29 cases reported by Parounagian and Goodman¹³, and 69 others in subsequent papers, and reports a case of his own. He concludes that the combination of diseases is most common in elderly men, varicella usually following zoster within five days, supporting the view that the eruptions are caused by identical or closely related organisms. Since his review, only one other

case¹⁴ has been reported, making a total of 100 cases. To these, I wish to add two cases.

Case 1. J. W., a white male, aged 75, a retired baker' was seen at home Aug. 17, 1939 for a typical attack of herpes zoster which involved the right upper lumbar segments, with an eruption extending around to his right groin, and some vesicles on the outer aspect of his right buttock. Treatment consisted of rest, local heat, local application of 10% ichthylol in collodion, analgesics and sedatives by mouth, thiamin chloride 2 mgm. t.i.d., and sodium iodide intravenously. 2 Gm. every other day. Four days later he complained of increasing malaise, and a vesicular eruption appeared on the front and back of his trunk, and some on his face and scalp. These did not follow the course of any nerve trunk, were diffusely distributed, and went thru the typical successive stages of chicken pox lesions. The herpetic lesions took considerable time to clear and there was much sloughing producing deep gyrating ulcers. He was left with a residual weakness of his right lower abdomen muscles which allowed a distinct sag in this region on assuming the upright position accompanied by considerable discomfort. A simple elastic abdominal support relieved the symptoms.

This patient did not recall whether or not he had had chicken pox in childhood, but he was most emphatic in the belief that he had 'caught' the 'Shingles' from a friend whom he had visited three weeks before the onset of his attack.

Case 2. R. F., white male aged 49, bookkeeper' came to the office Jan. 5, 1940, complaining of pain and soreness in his left chest, front and back, for the past three days. He had a well developed herpetic eruption of the left second dorsal segment extending around to the front, and some of the vesicles were on the upper, inner aspect of his left arm, and on the anterior axillary fold. Treatment instituted was the same as for case 1. Two days later I was called to see him at home because he had had a chill, and his temperature went up to 102.2 by mouth. He had a vesicular eruption on the front and back of his trunk, face, and scalp. Both conditions cleared uneventfully. He was quite sure he did not have chicken pox previously.

Summary and Conclusions

A review of the literature bearing on the studies of the two diseases, herpes zoster and chicken pox, has revealed considerable evidence favoring the view that there is a close relationship between them, and even that they may be caused by the same virus.

As for the simultaneous occurrence of these two conditions in the same patient, 100 cases have been reported up to the present, and I have added two more.

It is not surprising that there are so few cases on record in spite of the common incidence of each disease alone, since chicken pox misses

acquired immunity. It would be an interesting few children and usually leaves a permanent study to check all cases of uncomplicated herpes for a previous history of chicken pox. If the history could be definitely relied upon, all these cases should have had varicella to substantiate their identity or relationship, or develop chicken pox as a complication. This type of study would furnish further evidence pro or con this relationship.

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Osteogenic Sarcoma

Case Report

W. BRADFORD WALKER, M.D., F.A.C.P.
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The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the *Journal*. The following from the Charlotte Hungerford Hospital is the second in this series. (The Editor.)

The Author—Ph.B., Yale, 1916. M.D., Yale, 1920. Chief Visiting Physician, Charlotte Hungerford Hospital, Torrington. Secretary-Treasurer, Litchfield County Medical Association. Fellow, American College of Physicians. Health Officer, Towns of Cornwall and Goshen.

History: Mrs. A. W., age 56, was first admitted to this hospital on June 19, 1939. She complained of weight loss and symptoms suggesting peripheral neuritis involving the right sciatic nerve distribution. Patient was discharged following a gastro-intestinal x-ray study which proved negative and a blood study which showed slight secondary anemia. Because of an increasing swelling in right thigh region, accompanied by no ulceration or redness of the skin, x-ray study of the right femur was done on October 21, 1939. Roentgenograms suggested a low grade osteoperiostitis simulating Garre's type of sclerosing osteomyelitis; however, the medullary widening and detached areas of ossification made it difficult to rule out endothelioma, Ewing's tumor or chondro-sarcoma. Patient was re-admitted to Dr. F. A. Sutherland service for bone biopsy on November 7, 1939. The cortex of the shaft below the trochanter was found firm and considerably thickened. A section of bone was obtained. In addition, a moderate quantity of material consisting of dark, gelatinous substance and grayish white, friable flakes was removed from the medullary cavity. Microscopic study of these specimens revealed no evidence of malignant change. This opinion was further confirmed by pathologists at the New Haven and Hartford Hospitals. Because the tumor continued to increase in size further x-ray studies were made on March 6, 1940. At this time a slight periosteal outgrowth suggested a sarcomatous change. Immediately thereafter a second specimen for biopsy was taken with the Feder needle. Again

local pathological opinion concurred in the conclusion that the process was non-malignant and probably represented only a degenerating chondroma. Soon afterwards Doctors Bradley Coley and Fred Stewart (Memorial Hospital, New York City) reviewed the patient's history, x-ray films and pathological sections and arrived at the diagnosis of central osteochondrosarcoma. Patient was re-admitted on May 22, 1940. After lung metastases were ruled out by roentgen study leg amputation was done by disarticulation at the hip joint. Convalescence was uneventful. Following discharge from the hospital patient remained comfortable and free from symptoms until a few weeks ago. Since then the tumor has recurred in the region of the acetabulum and has grown rapidly. It is now causing considerable pain.

Discussion

Doctor W. B. Walker: The specimen consists of the upper half of the femur. There is a tumor mass measuring six inches in the greatest transverse diameter involving its upper portion. The tumor has involved the shaft, has invaded the marrow spaces and has penetrated the cortex. The tumor is composed of numerous, soft, friable areas in a frame work of much firmer tissue. It is surrounded by a capsule which has not been eroded. The head of the femur is only slightly involved. From the gross appearance this is evidently a malignant tumor growth with much myxomatous degeneration. This case illustrates well what may happen if we place too much dependence on laboratory services. After open and aspiration biopsies the pathologists were unable to make an accurate diagnosis and after x-ray studies pointed to the possibility of bone sarcoma the radiologists were not sufficiently positive of this

diagnosis to advise amputation. In the presence of a rapidly growing, bone tumor, it would have been better clinical judgment obviously to have amputated earlier. Regardless of the plan of treatment adopted in malignant osteogenic sarcoma the prognosis is poor because of the extreme likelihood of late pulmonary metastases, but despite this comforting thought I feel that there was unwarranted delay in amputation because we did not rely strongly enough on clinical judgment and depended too much on the laboratory.

Doctor R. T. Ogden: A positive diagnosis of malignancy can not be made from the x-ray. You would have been open to severe criticism had you amputated without a definite diagnosis of malignancy and discovered later that the lesion was an osteoperiostitis. This is an unusual case as in most instances a definite diagnosis can be established by x-ray and biopsy. Did this mass occur after surgical incision or was it there before?

Doctor W. B. Walker: Physical examination before the original biopsy showed a marked prominence over the upper thigh region with a swelling of the soft parts over the trochanter.

Doctor C. J. Bartlett: The picture seen in the sections is quite similar to that described from the aspiration biopsy made in April, 1940, except that in some areas there is more definite cartilage. In general the myxomatous material contains a comparatively small number of cells. While from the gross appearance this is definitely a malignant tumor growth I should have hesitancy in pronouncing it such from the sections alone. As I had shown the two previous sections to Doctor Zimmerman of the New Haven Hospital I took occasion to show him both the gross specimen and microscopic sections from this tumor and I think the above expresses his opinion as well as my own in this case. From the gross and microscopic examination I think this is probably a secondary myxomatous chondro-sarcoma.

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(SEE PAGE 2)

State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

Have Adults Adopted the Tablet Form of Diet?

ELIZABETH C. NICKERSON, B.S., C.P.H.
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The Author—Elizabeth C. Nickerson, B.S., C.P.H., has served as Director of the Bureau of Public Health Instruction and Nutritionist of the Connecticut State Department of Health since the bureau was authorized by the General Assembly in 1923. Miss Nickerson majored in nutrition under Professors Henry C. Sherman and Mary Swartz Rose at Columbia University and did graduate work in nutrition and public health education at Massachusetts Institute of Technology in its Department of Biology and Public Health.

Many years ago when science indicated the possibility of putting together a synthetic diet which would meet all human needs, it was suggested that a beefsteak dinner in the future might be served up in tablet form! This idea fired the imagination to such an extent that it became the butt of many a joke and the theme of many cartoons. Today, with our knowledge of scientific nutrition crystalized, it would seem more and more impossible to conceive of such an all inclusive "tablet diet." It would have to contain some twenty or more inorganic elements, some ten essential amino acids, as well as carotene, thiamin, ascorbic acid, vitamin D, riboflavin, nicotinic acid and other vitamins less well established as essential to human nutrition. Furthermore, all these elements would have to be so well proportioned as to meet the varying needs of age, sex and activity.

Since the mystery of the unknown vitamins has been removed through the discovery of their chemical structures, it is now possible to secure on the market in tablet form all the vitamins that can be made synthetically and others which are concentrates of vitamins as they occur in natural foods. Unfortunately, scientific nutrition researches in connection with the

vitamins have been so widely exploited that many people are led to believe that health depends upon the daily use of an assortment of vitamin tablets from A to Z. These may be purchased at their favorite department stores and many of the concentrates are now on sale at the neighborhood chain stores. Magazine and newspaper advertisements extoll their health benefits and thus lead people to believe that health definitely may be purchased in this form.

Vitamins Not All

While scientific research has given convincing evidence of the importance of the vitamins in human nutrition, it has just as conclusively shown the need for various mineral elements, particularly calcium, phosphorus, iron and copper, for protein of a high biologic value and for sufficient calories to meet the varying activity needs of the body. No one food is the all important factor in nutrition since there is an intimate relationship among all the essential factors: carbohydrates and fats have a "sparing" influence on protein metabolism; without a balanced and adequate supply of calcium and phosphorus vitamin D is of no avail; calcium and phosphorus work together to give rigidity to skeletal and dental tissues; without traces of copper, iron is not adequately used; without calcium vitamin A will not support growth and vice versa; without some protein from animal sources the essential amino acids will not be available for growth and functioning of body cells; vitamin B₁ or thiamin bears a close relationship to the oxidation of carbohydrate foods, so the one whose activities are greater requires more of this vitamin.

Since it is obviously difficult to supply all the body needs in tablet form, the human race may still continue to indulge in the pleasure of eating foods as they are seasonally available and in quantities best suited to their needs. Unless some pathological condition necessitates emphasis on or elimination of one or more individual food factors such as one of the vitamins or one or more of the mineral elements, it is well to keep a well rounded viewpoint of complete nutritional needs. The over publicized daily supply of "vitamin tablets" may indicate the short cut to nutrition but they

give a false picture of the daily needs. Furthermore, vitamins in synthesized products are not as effective as when taken in their natural state in foods. Real foods with their intermingling of vitamin, mineral and protein content make for greater efficiency in producing health results. Vitamin tablets prescribed to offset some pathological condition may be justifiable in certain instances; to use these daily without giving thought to the daily foods which will supply such elements even more efficiently and at much lower cost is to acquire a false sense of health security.

PROTEIN, MINERAL AND VITAMIN CONTENT OF SOME COMMON FOODS**

Food	Calories	Measure	Protein	Essential Mineral Elements			Vitamins*			
				Calcium	Phosphorus	Iron	A	B ₁	C	G
			Grams	Grams	Grams	Grams	I U	I U	I U	S U
Dairy Products										
Milk	170	1 cup	8.1	.291	.230	.0006	386	27	54	78
Cream, thin	100	¼ cup scant	1.3	.050	.044	.0001	284	—	—	—
Cheese, American	100	1⅛" cube	6.5	.211	.159	.0003	432	3	—	46
Vegetables										
Potatoes, white (baked)	100	1 medium	2.6	.014	.064	.0011	25	24	130	30
Potatoes, sweet (baked)	100	½ medium	1.5	.017	.037	.0006	1561	21	75	28
Carrots, cooked	25	one	0.6	.025	.023	.0003	1284	10	23	28
Carrots, raw	5	1 tbsp. grated	0.1	.005	.005	.0001	256	3	7	6
Cabbage, chopped, raw	12	½ cup	0.6	.018	.013	.0002	18	10	218	19
Celery, raw	12	½ cup cut	0.8	.048	.029	.0004	7	7	62	—
Kale, cooked	19	½ cup	1.3	.066	.024	.0009	7047	6	+	72
Lettuce	6	2 large leaves	0.4	.006	.014	.0002	31	7	24	9
Onions, cooked	50	1½ — 2	1.6	.042	.048	.0005	—	4	100	14
Peas, green, cooked	100	¾ cup	7.0	.023	.127	.0020	750	113	200	100
Peppers, green	10	½ pepper	0.4	.004	.010	.0001	207	2	690	+
Spinach, cooked	20	½ cup	1.7	—	.038	.0021	9280	24	370	83
String Beans	25	⅝ cup	1.4	.033	.030	.0007	452	7	55	15
Tomatoes, fresh	50	1—2 medium	2.9	.024	.069	.0011	1428	42	850	48
Tomatoes, canned	50	1 cup	2.9	.024	.069	.0011	1428	42	850	48
Dried Beans	100	⅝ cup scant	6.5	.043	.134	.0029	10	37	—	+
Fruits										
Oranges	100	1 large	1.8	.053	.041	.0011	95	73	1180	61
Orange juice	100	¾ cup	1.1	.035	.024	.0004	96	73	1190	64
Lemons	30	1 medium	0.7	.016	.007	.0004	—	+	444	+
Grapefruit	100	½ medium	1.7	.044	.043	.0006	—	22	1380	85
Apples	100	1 large	0.6	.013	.020	.0006	89	20	160	32
Bananas	100	1 medium	1.3	.008	.030	.0006	119	15	170	30
Peaches, fresh, yellow	100	2 medium	1.0	.020	.038	.0007	2940	+	180	—
Pineapple, fresh	100	2 slices ¾ "	0.7	.014	.019	.0007	78	44	440	44
Pineapple juice	100	⅔ cup	—	.024	.017	.0002	120	53	210	15
Apricots, dried	100	9 halves	1.7	.023	.043	.0027	1890	+	140	34
Apricots, canned	100	3 halves & 2 tbsp.	1.3	.014	.026	.0005	++	+	+	+
Prunes, dried	100	4 medium	0.7	.019	.028	.0010	500	13	50	87
Prunes, cooked	100	2 & 2 tbsp. juice	0.4	.011	.016	.0006	280	6	21	50
Raisins	100	2 tbsp. seedless	0.8	.017	.038	.0009	21	9	—	14

Food	Calories	Measure	Protein	Essential Mineral Elements			Vitamins*			
				Calcium	Phosphorus	Iron	A	B ₁	C	G
			Grams	Grams	Grams	Grams	I U	I U	I U	S U
Cereals, Breads										
Oatmeal	100	½—¾ cup	4.2	.017	.098	.0012	—	30	—	+
Wheat, shredded	100	1 biscuit	3.3	.011	.089	.0012	3	13	—	22
Wheat, germ	100	⅔ cup	6.8	.018	.260	.0019	+	300	+	75
Cornmeal, yellow cooked	100	⅔ cup	2.6	.005	.043	.0003	126	18	—	9
Farina, dark, cooked	100	¾ cup	3.0	.013	.118	.0014	3	17	—	22
Farina, light, cooked	100	¾ cup	3.0	.006	.035	.0002	—	—	—	—
Corn flakes	100	¾ cup	2.1	.004	.029	.0007	—	—	—	—
Bread, white	100	2 slices	3.6	.010	.036	.0004	—	—	—	—
Bread, whole wheat	100	1½ slices	4.0	.020	.062	.0007	+	61	—	+
Bread, rye	100	2⅔ slices	3.6	.010	.059	.0006	+	22	—	+
Eggs, Meat, Fish										
Eggs	70	one	6.3	.029	.106	.0014	702	14	—	68
Beef, round	100	slice 2-¾"	13.6	.008	.130	.0019	30	16	—	64
Lamb	100	slice—3½"	10.2	.006	.110	.0008	—	19	—	+
Pork	100	½ chop	8.1	.003	.099	.0008	+	56	+	40
Beef liver	100	slice 4" x 3"	15.8	.009	.286	.0064	5670	39	+	694
Chicken	100	3 slices 3½"	19.9	.012	.215	.0030	—	+	—	+
Cod fish	100	pc. 3¾ x 2½"	23.7	.013	.238	.0005	5	12	—	+
Salmon canned	100	⅝ cup	14.8	.050	.214	.0010	170	13	—	60
Nuts										
Peanut butter	100	1 tbsp. scant	4.9	.012	.066	.0003	+	20	—	36
Peanuts	100	20 —24	4.7	.012	.072	.0004	+	20	—	36
Almonds	100	12 —15	3.3	.040	.071	.0061	+	7	—	+
Pecans	100	12	1.3	.012	.046	.0004	21	7	—	—
Walnuts, English	100	8 — 16	2.6	.013	.051	.0003	+	22	—	—
Fats and Sugars										
Butter	100	1 tbsp.	0.1	.002	.002	—	384	—	—	—
Oleomargarine, vit. A added	100	1 tbsp.	0.3	.004	.004	.0001	384	—	—	—
Lard	100	1 tbsp. scant	—	—	—	—	—	—	—	—
Olive Oil	100	1 tbsp.	—	—	—	—	—	—	—	—
Cod liver oil	100	1 tbsp.	—	—	—	—	3585*	—	—	—
Sugar, white	100	2 tbsp. scant	—	—	—	—	—	—	—	—
Sugar, brown	100	3 tbsp.	—	.023	.003	.0007	—	—	—	—
Honey	100	1 tbsp.	0.1	.001	.006	.0002	—	—	—	—
Molasses	100	1½ tbsp.	0.8	.090	.010	.0025	—	—	—	—

*Vitamin D is not listed in this table since food sources are more or less negligible. Beside cod liver oil, fish that contain some body oil such as salmon, sardines and herring are sources of vitamin D. Egg yolk also contains this vitamin, and traces are found in milk fat and meat. Cod liver oil — U.S.P Standard. For various brands see container.

**Table adapted from Mary Swartz Rose, "Feeding the Family". By permission of the Macmillan Company, publishers.

Selecting Foods to Meet Daily Requirements

The accompanying table listing simple foods for daily living shows how richly certain of these supply all the vital elements — protein, calcium, phosphorus, iron and vitamins A, B, C, G needed for growth and health. Foods devoid of such vital elements are also listed by way of contrast. The minerals listed in the

table — calcium, phosphorus and iron — are the essential elements that foods must furnish daily in order to meet the recognized daily standards of:—calcium, 1 gram for children, 1.5 grams during pregnancy and lactation and 0.75 gram for adults; phosphorus, 1 gram for children and 1.32 grams for adults; iron, .012 — .015 gram for children and adults, and .018 — .020 gram during pregnancy and lactation.

Suggested Daily Vitamin Requirements*

Vitamin A Measured in International Units
Adults: 2000-4000 I U

Children: (2-14 yrs.) 6000-8000 I U

Pregnancy and lactation: 5000 I U

Vitamin B₁ (thiamin) Measured in International Units

Adults: 250-400 I U (based on 15 I U per 100 calories)

Children: 20-25 I U per 100 calories

Pregnancy and lactation: 15-20 I U per 100 calories

Vitamin C Measured in International units, or mg. of ascorbic acid

Adults: 1200-2000 I U, or 60-100 mg.

Children: 1200-2000 I U, or 60-100 mg.

Pregnancy and lactation: 50 per cent increase over normal needs

Vitamin G (riboflavin) Measured in Sherman Units

Adults: 600 S U (based on 20 S U per 100 calories)

Children up to 10 years: 400 S U; with over 2000 calories, same as adult standard.

*See "The Vitamins", American Medical Association

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GROUP HEALTH COOPERATIVE, INC.

According to the *New York Times* that State now has its first cooperative health insurance corporation organized under the new law permitting non-profit underwriting of medical expense. Group Health Cooperative, Inc., has already enrolled 150 physicians, according to the *Times*, and for a premium of five cents a day the corporation offers general medical care, specialist attendance where necessary, maternity care after the first twenty months of enrolment of both parents, laboratory and some x-ray services. There is said to be no limit to the amount of care the insured is entitled to

during the year. The corporation is licensed to do business in the eleven southern counties of the State, although for the present it plans to confine its activities to New York City and Westchester.



PSYCHIATRISTS ORGANIZE FOR PUBLIC EDUCATION WORK

Organization of twelve regional districts, each headed by a nationally known psychiatrist to cooperate with the press and otherwise to foster the dissemination of sound psychiatric information to the public, was announced recently by Doctor Charles Burlingame, Chairman of the Committee on Public Education of the American Psychiatric Association. The chairman for this regional district is Doctor Merrill Moore, Boston, Massachusetts, member of the faculty of Harvard Medical School.

In announcing these appointments Doctor Burlingame stated, "The Association has long felt it desirable to have decentralized public education work along psychiatric lines. Physicians who are more closely in touch with local conditions and local needs are in a much better position to interpret the policies and aims of the Association, and with better results because they are thinking in terms of the realities of local conditions."

Doctor Burlingame expressed the hope that this new setup would be useful to the press of each community in giving them an authoritative source of information on psychiatric matters. He indicated also, that an important phase of the work would be to make known the Association's policy with regard to mental hospital standards as the occasion required. "There are few mental hospitals in the country which even now attain the minimum standards of care as outlined by the Association," he said, "and from time to time there is danger of still further lowering of standards by reason of political manipulation, or through a lack of understanding that mental patients need and deserve to have the same high standard of medical care as obtains in the general hospital. One of the principal aims of this organization will be to acquaint the public with the fact that a well-staffed, well-equipped hospital for the care of the mentally ill is not a luxury, but a basic necessity in any civilized community."

New Year's Message from the President

Connecticut State Medical Society

Though this year dawns over a world sick with political upheavals, its beginning, none the less, excites in us the same hopes and aspirations which have absorbed generations from this anniversary down the centuries. Through frustration and adversity man has not despaired and he will again face the new year resolved to conquer the things that would enslave him or thwart his efforts toward greater achievement.

But it must be remembered that too often in perennial resolutions there is a blind optimism which ends in delusion. Realism, not fantasy, engenders hope and safeguards against disappointment.

For the medical profession, the new year is ushered in under not altogether happy augury. Socialized medicine, although overborne by more momentous problems, still is our concern. Legal action against the profession lies but dormant. The call to military service awaits many. Group medicine signalizes changes in practice, and the doctor's income, as well as that of others, is due for additional taxation. Sacrifices are inevitable.

Organized medicine resolves to meet its problems with energetic leadership and in the democratic way. The doctor still has his place in the council of men and will continue to envisage the stern realities ahead with faith in God and confidence in himself. Through organization and cooperation we should reach the goal of good medicine for all with just compensation for the practitioner.

ARTHUR B. LANDRY, M.D.

The Connecticut State Medical Journal

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month — day of month if weekly — and year.

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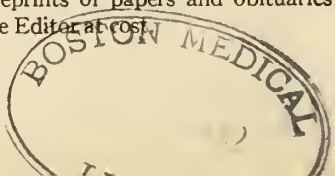
• Editorials •

INSURANCE PREMIUMS IN WAR EMERGENCY

The New York State Journal of Medicine* has recently given prominence to the discussion of the physician's life insurance in war time. In order to intercept any false interpretations or deductions a clarification of the subject is imperative. The voice of experience and, may we add, of authority, which the New York editor is pleased to ascribe to us, should logically come from Hartford, the insurance center of the nation. The payment of all types of insurance premiums becomes a serious problem for either physician or layman in the event of military service. Insurance carriers of accident and health policies are ruling that such policies shall continue in effect only provided that the insured remains within the United States or Canada, that he does not enter the air service, and provided that this nation does not engage in actual warfare. Life insurance is, of course, only one of the serious financial problems facing physician or layman who enters military service. He may be encumbered with mortgage payments on his home, monthly installments on his automobile or gas refrigerator, or interest on financial loans. The pay of a first lieutenant or of a captain will undoubtedly fall far short of the necessary income to meet these obligations.

Our friends in New York commit a fundamental error when they reason that to borrow on a life insurance policy represents the insured's own money loaned back to him by the insurance company. A man does not borrow "his own" money when he borrows on a policy, but, rather, he enters into an agreement with the investment department of the insurance company whereby this same company agrees to invest some of its money with him, provided he pays interest for the use of it. This process is entirely comparable to the investment of money by the life insurance company in real estate and in investment securities, but in any event the company must realize a return on money invested in order to maintain solvency. Borrowing money from an insur-

*Editorial, N. Y. State J. M., July 15, 1940



ance company by an individual is no different from borrowing money from a bank. In the second instance the bank requires collateral of securities, or other tangibles, while the insurance company accepts a life insurance policy as collateral up to the amount of reserve which has accrued against the policy.

Automatic extension of insurance at the face value of the policy for a period dependent upon the amount of cash reserve in the policy has been suggested as a solution of the physician's difficulties in meeting premium payments. The question is, why limit the moratorium to life and accident premiums? It could as fairly be applied to any current debt or obligation incurred by any individual who may become a part of the fighting forces of the United States. What would be the result upon the economic system if such a procedure became legalized? Let us not forget that a life insurance policy may be paid for in full if the insured so desires. Furthermore, if a continuation of the payment of life insurance premiums is not desired for any policy, the insured is protected through paid-up insurance for 100% value of all premiums paid up to the time of the cessation of premium payments and, therefore, no further premium payments need be paid.

Our neighbors from New York, "to provoke discussion of this subject," have suggested a transfer of insurance from private to government control. This invites the entrance of the government into the field of insurance. During World War I the government sold cigarettes at seven cents a package at army posts, while the same product was sold elsewhere at fifteen cents a package. How was the difference in selling price made up? How will the difference between the premium charged for government insurance and the actual cost of the insurance to the government be met? The answer, obviously, is by taxation toward which every one contributes. How far do we wish to permit the government to be projected into private enterprise? If it is going into business at all, why not into all fields? Can the government handle any business as efficiently as is possible under good private management? How great a degree of efficiency in business may one expect from the government when the results of lack of efficiency, lack of

judgment, lack of foresightedness, and lack of honest endeavor can always be compensated for by an increase in taxes? Will the change of operating personnel under government control due to the change in administrations tend to keep the level of efficiency as high as under private enterprise?

It requires no deep study on the part of well informed citizens to realize the repercussions of the T.V.A. experiment where taxation is concerned. Private enterprise is based on the premise, "be successful or you perish," and that is an impelling incentive for the achievement of success. Such an incentive would be non-existent under government control. Government securities do not in themselves yield sufficient income to insure the solvency of any insurance organization. The government itself can make up this deficiency only by increased taxation, but the source of supply will fail if business is choked by a moratorium and the natural flow of money necessary to carry on all business is thereby reduced.

There is most assuredly no novel or magic way of providing for life insurance premiums of those engaged in the business of military training. The mysteries of the Aladdin-like legerdemain performances in Washington have long since been divulged. Financial obligations, including life insurance premiums, cannot be suspended nor can protection exist for the physician only insofar as he pays for it. The hard way remains the only way for us, as for countless others in the disrupted world of today.

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VITAMINS — THE NEED FOR A PROPER PERSPECTIVE

Developments in the field of the vitamins have come so rapidly in recent years, and have been capitalized so extensively by various parties, that a note of caution sounded in a medical journal may appear to many to be just another example of overconservatism on the part of the medical profession. Nevertheless it is advisable to ask that the vitamins be viewed with a proper perspective. The science of nutrition has revealed that approximately thirty-six different factors are needed to secure adequate nourishment of the body: the known

vitamins constitute only about one-third of them, mineral nutrients roughly another third, and the essential amino acids of protein, essential fatty acid and calories the remainder. Adequate nutrition demands that all of these requirements be met, not merely those of the members of the vitamin group, but those of the others as well. Furthermore, practical application of this field of knowledge to such problems as feeding people on relief, a situation which obviously calls for making the best possible use of food materials at a minimum of cost, means that the need for energy must be met first if the people in question are not to complain of "being starved," with the foods furnishing this energy being properly selected so as to be, as far as possible, carriers of the other needed essentials. For normal people who are under no economic restraint in the selection of their food, the obvious solution of the problem lies in the proper selection of wholesome natural foods. For the people in the low-income groups our social objective should be to see that all of the staple foods that are readily available in the grocery store have been returned as nearly as possible to the state they were in before being processed.

There is no doubt that the various pure vitamins should be available in the drug store to the physician who desires to use them in the treatment of specific disease. Since the vitamins are fundamentally foods there is some justification for having them available in a form useful for supplementing the diet when there is reason to believe that this is needed to secure adequate nutrition.

It may be seriously questioned, however, whether any large part of the vitamin purchases now made by the general public is in accordance with any thought-out plan that can be justified on physiological and medical grounds; it is much more likely that it is of the indiscriminate sort based on such a vague reason as, for example, "it must be good for you because everybody says so." The public needs education in this matter and the physician should take an active part in this educational work. This should involve education with respect to the place in the diet of the protective foods, the avoidance of extremes in dietary habits, and appreciation of the fact

that mankind has lived for millenia without ever knowing that such a thing as a vitamin exists.

G. R. C.

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THE LOST ART OF PRESCRIPTION WRITING

Today the detail man from a large drug concern visits you; tomorrow you prescribe one or more of his products for several of your patients. Perhaps you do not even do this but instead hand your patient a sample of some drug in its original container, all labeled with the name and the directions for its use. Or, instead, you may direct your patient to ask for a certain number of capsules of some preparation over the counter of the pharmacy. How many of our physicians today take the time to write a prescription for a U.S.P. or N.F. product? How many in writing for more than one ingredient in a prescription are familiar with incompatibilities that may arise?

The last products left by a detail man are not always "Council accepted" nor have they withstood the test of time. Many will be forgotten by tomorrow and serve but to collect dust on the pharmacy shelves. If you must present your patients with samples do the patient, the druggist, and yourself the justice to remove them from their original container and label them yourself as you wish your patient to use them. No greater evil exists today than that of the wholesale purchasing of drugs over the counter by the laity, your patients, because you first gave them a sample already labeled by the manufacturer.

Your pharmacist is endeavoring to conduct an ethical prescription business. He must have your support. Your prescriptions should be intelligently written, preferably with U.S.P. or N.F. preparations. Your patient should never be directed by you to purchase a quantity of any drug over the counter for by this procedure you are doing him an injustice. The increased use of the barbiturates continues to present an unsolved problem and the purchase of drugs over the counter does not tend to lessen the element of danger.

CITIZENSHIP — LICENSURE

In 1938 the Connecticut State Medical Society appointed a committee to revise the medical practice act. The House of Delegates at its meeting in December approved the revision. Included in the revision is the requirement of citizenship. All but four states and the District of Columbia now require citizenship or first papers. During 1939 and 1940, 54 per cent of the applicants for licensure in Connecticut were graduates of foreign medical schools. A large percentage of these were immigrant physicians. In the past ten years nearly five thousand immigrant physicians have arrived in this country.

In the past the constitutionality of the citizenship requirement has been debated. During the past year existing conditions in this country seem to have swung the pendulum of opinion in favor of the requirement. It has generally been held that it is constitutional to require citizenship of lawyer applicants for admission to the bar. The reasoning is that members of the bar are officers of the court and therefore officers of the state. It would appear that in general the same premise would hold for physicians. The physician by morals and law must participate in the enforcement of the public health laws. Frequently the physician is called upon to determine the ability of people to execute vital public records. He is at times called upon to aid in the enforcement of state and federal laws. Probably the most compelling reason is the great trust and responsibility placed in physicians by the National Defense Act. The constitutionality of the requirement was upheld by the District Court of Travis County, Texas, last year. Amongst other reasons, counsel for the Texas Medical Society in its brief held that the practice of medicine was a privilege and not a right and that the state could impose any restrictions respecting this privilege which were reasonable.

All who have had contact with immigrant physicians cannot help but feel for them in their sad plight. The most meritorious argument against requiring citizenship is that these men in general will not be any better physicians after five years than they are now. This argument is difficult to refute.

It is a situation requiring serious thought

and should not be passed lightly. At the same time it should be treated fairly and without bias. Under existing conditions, particularly with reference to the Defense Act, the reasoning seems to favor the requirement.

T. P. M.

* * * *

WHAT IS THE SOLUTION?

Professor Winslow of the Yale School of Medicine has placed squarely before the profession an outline of adequate medical care. (See page 7). It does not call for fee-for-service care alone nor for compulsory health insurance alone but allocates to each economic group in our population that form of medical service best adapted to the particular group. While the reactionaries are crying loudly for a maintenance of the old methods of medical care and, on the other hand, the Social Security-ites are demanding legislative changes permitting the establishment of compulsory health insurance, it is encouraging to know that there may be a plan for medical care which includes virtually all the plans now being proposed by organized medicine, organized labor, and the sociologists.

The New York State Medical Society is experimenting with cash indemnity plans for medical care. This is commendable and the results will be watched with considerable interest. As the editor of its official publication has said, "neglect by the profession and the people to study and to create workable devices based on the insurance principle wherever possible is — inexcusable." The *New York Times* has repeatedly objected to the honest efforts of organized medicine in New York State to find by the process of experimentation some satisfactory plan for medical care, and this objection is kindled and fed by the presence in that State, and in Metropolitan New York particularly, by a group who can see no good in any plan which does not completely denounce the platform of the American Medical Association.

To such, as well as to our own medical leaders in Connecticut, we recommend Professor Winslow's opinions as worthy of careful study. It may be possible to maintain a fee-for-service plan for those in the high income

brackets, voluntary health insurance for those in the middle economic group, compulsory health insurance for the low income group, and free care at public expense for the indigent — all this with quality not lost sight of as a *sine qua non* of any plan for medical care.

* * * *

THE NATIONAL PHYSICIANS COMMITTEE AFTER THE ELECTION

Many have asked what the National Physicians Committee for the Extension of Medical Care is doing at present, what are the plans for the future since the question of compulsory insurance has been relegated into the legislative background by the larger and more important problem of National defense? In a statement recently issued by this Committee we are informed that "two years of aggressive effort in defining and clarifying the issue (political control of medicine), in unifying the profession and informing the public has produced spectacular results." Public opinion has been affected by the work of this Committee and, as the Committee points out, the attitude of President Roosevelt towards the medical profession, expressed in his speech at the dedication of the National Institute of Health in Maryland, has been changed. The medical profession today represents the only important group in the United States which has shown toward Federal meddlers no signs of capitulation or even of retreat, while being harassed from within and without.

The National Physicians Committee believes that a fifth column menace threatens our free institutions and that just so far as we move toward a form of totalitarian control, so far will the practice of medicine in this country be affected.

The Committee plans to push the advantages thus far gained by further education of the public in a knowledge of the underlying principles of individual freedom, the "American Way of Life". It is planned to keep a continuous flow of articles going to more than eighty medical journals, to stimulate discussion of this important issue in all the State, county and sectional medical meetings, to arrange for the publication of releases for thousands of newspapers and hundreds of magazines, to supply speakers for medical and public meet-

ings and for radio broadcasts, to maintain strategically important public contacts, and to arrange for conferences with various groups, — hospital boards, industrial organizations and lay societies.

All this is planned with a view to preventing the political control of medicine and the maintenance of the independent pattern of medical practice. Although the Wagner National Health Bill has passed into the limbo another bill of similar portent will make its appearance in 1941, that is certain. To carry on this important work the Committee needs financial support. Many of our members and some of our County and City societies have contributed. Three cents a day from every physician in Connecticut would constitute a valued contribution. Some can give more; not all will be as generous as the members of the Harris County (Texas) Medical Society, who recently contributed the grand total of \$2,313.50.

* * * *

ARE YOU REGISTERED WITH THE STATE DEPARTMENT OF HEALTH FOR 1941?

Just a reminder that the state law requires each physician to register annually with the State Department of Health during the month of January. Application for re-registration is attached to the receipt sent you in 1940 and no other applications will be sent. Please send in your application *now*.

* * * *

HAS YOUR NURSE REGISTERED FOR 1941?

Every nurse and trained attendant who registered for active practice in Connecticut this year was sent a receipt card, with an attached stub for re-registration in 1941. No reminders will be sent this year, as has been done in the past. The responsibility for re-registering before January 31st, with the Connecticut State Department of Health, is now left with each nurse and trained attendant.

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

Anonymous Member Gives Funds To Finance Preparedness Activities

A generous member of the Society, who wishes to remain anonymous, has given the Secretary's office six hundred dollars to defray the expenses of additional clerical and stenographic assistance that has become necessary to carry out the Society's military preparedness program. This help is needed in the Secretary's office and the Society expressed its gratitude to the donor by a unanimous vote of thanks passed by the House of Delegates on December twelfth.

* * * *

December Council Meeting

The Council held its regular monthly meeting on December twelfth.

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Amendment to Nursing Practice Act

The Secretary was directed to present an amendment to the Nursing Act before the General Assembly of 1941. The proposed amendment concerns the employment of personnel in physician's offices.

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Authorization of Autopsies by Medical Examiners

The Council adopted the report of the special Committee to Study the Medical Examiner System and directed the Secretary to present an amendment before the General Assembly of 1941. The proposed amendment will seek to increase authority of medical examiners to procure autopsies in cases of sudden death or when the cause of death is uncertain. The complete and informative report of the Special Committee is published elsewhere in this issue.

Representative at Third Annual Congress on Industrial Health

The Council voted that Doctor Clifford Kuh, Chairman of the Committee on Industrial Health, represent the Society at the Third Annual Congress on Industrial Health in Chicago, January, 1941.

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Approval of Hospital Plan Group for Members of the Society

The Council approved the organization of a group of subscribers to the Connecticut Plan for Hospital Care from the membership of the Society.

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Sesquicentennial Committee

The Sesquicentennial Committee met on December twelfth. The Chairman, Doctor George Blumer, presided and the preliminary outline of the program for the celebration as presented by the Planning Committee was discussed. It was tentatively decided that the meeting be held in Middletown late in June 1942.

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Committee to Revise the By-Laws

The special Committee to recommend revision of the By-Laws of which Doctor D. Chester Brown is Chairman, has held two meetings during the past month and its members are actively engaged on the Committee's important and difficult task. Suggestions concerning the new By-Laws will be welcomed by the Committee.

* * * *

PLEASE SEND YOUR RESERVATIONS
FOR THE MIDWINTER DINNER
TO THE SECRETARY'S OFFICE
NOW.

SPECIAL MEETING OF THE HOUSE OF DELEGATES

Budget

The House of Delegates held a special meeting in New Haven on December twelfth to act upon the Society's budget for 1941. The budget was adopted as published in the December Journal. It appropriated nine hundred dollars less than for 1940; the saving is due to the increasing advertising revenue from the Journal.

Exemption from Dues for Members in Military Service

Members who enter active military or naval service will be exempt from the payment of dues to the Society in accordance with a resolution passed by the House of Delegates.

"On and after January 1, 1941, members of this Society who are engaged upon full time active duty with the United States Army, Navy or Public Health Service shall, upon their own request, be exempt from payment of dues to this Society for the period that they are engaged upon such full time active duty.

Exemption from payment of dues shall be pro rated upon a monthly basis equal to one-twelfth of the total annual dues assessed by the Society and the period of exemption shall commence on the first day of the month following entrance into full time active service and terminate on the first day of the month following return to a civilian status. Application for such exemption should be addressed in writing to the Treasurer of the Society, 258 Church Street, New Haven. In the event a member has paid his dues in advance for the year and subsequently enters full time, active, military service, the Treasurer is authorized to remit to that member at the end of the year such part of the dues paid as may cover the time spent in full time, active, military service, pro rated upon a monthly basis."

House Votes to Take No Action on Birth Control Legislation

The House, with two negative votes, adopted the resolution concerning birth control legislation that had been submitted by the Public

Health Committee and approved by the Council. The resolution:

"After considerable investigation and discussion the Public Health Committee wishes to report to the Council of The Connecticut State Medical Society that in the opinion of the Committee it is inadvisable for the Society to take any action at this time on the contraceptive law. Nothing in this recommendation is to be construed as a limitation or restraint of the rights of any member of the Society as an individual."

Amendments to Medical Practice Act To Be Introduced

The amendments to Section 2741, 2742, 2747 and 2749 of the Revised Statutes of the State of Connecticut that were proposed by the Society's Committee to Study the Medical Practice Acts were approved by the House and the Secretary was directed to introduce bills before the 1941 General Assembly providing for the proposed changes.

The New England Postgraduate Assembly

The House, with the approval of the Clinical Congress Committee, voted that the Society join the other New England States in sponsoring the New England Postgraduate Assembly. The Council will designate two members to represent the Society on the Assembly Committee.

* * * *

REPORT OF COMMITTEE TO STUDY MEDICAL EXAMINER SYSTEM

The Committee to Study the Medical Examiner System, appointed by the Council of the Connecticut State Medical Society on May 31, 1940, held meetings on July 29, November 14, and November 27, 1940. In addition to attendance at these three meetings, each member of the Committee consulted a number of well-informed persons. The Secretary of the Society supplied the members of the Committee with copies of the Connecticut State statutes regulating the conduct of the offices of the county coroners and with other pertinent material.

In the latter part of October the Committee circulated a questionnaire among the Medical Examiners of Connecticut. After the replies had been assembled the Committee held a conference with the executive Committee of the Connecticut State Association of Medical Examiners. This conference brought out valuable information and showed that the Executive Committee of the Association and this Committee are in accord in this attitude toward the main issues under discussion.

Information gathered by the Committee indicates

clearly that the coroner-medical examiner system now in operation in Connecticut is not satisfactory. The system fails to provide an efficient and up-to-date medico-legal service for the administration of justice, and does not sufficiently serve the general welfare in the fields of medicine and public health. Thorough improvement of the system cannot be made without extensive changes in the statutes. Full utilization by the State of the possibilities for public service and the advancement of knowledge which are inherent in the medical examiner system cannot be made until a broader viewpoint becomes accepted and supported by opinion which would lead to far reaching revisions of the laws.

Some of the questions which the Committee considered in discussions of such changes are: drastic changes in the office of the coroner, changes in procedure of appointment of medical examiners, separation of the authority of the medical examiner from that of the coroner, establishment of an office of chief medical examiner, establishment of a central laboratory for pathology and toxicology, assignment of the medical examiner system to another division of the State government than the judiciary, arrangements for ensuring cooperation of various State agencies in all phases of medico-legal work, and finally the development of the medical examiner system as productive means for the advancement of knowledge and practice in the fields of medicine and public health.

At its first meeting the Committee agreed that it would not be feasible for it to attempt to recommend drastic changes in the office of the coroner. The Committee believed that its primary concern was with the medical examiner system. Therefore the Committee concentrated its attention on the functions and authority of the medical examiner. Several far reaching plans and possibilities were discussed. Much time, probably more than a year, would be needed for a thorough study of these possibilities before any comprehensive recommendations could be made. An improvement of considerable importance, however, could be secured promptly if the medical examiners were given power to order and secure the performance of autopsies. The Committee presents the following recommendation on this point:

It is recommended to the Council that a bill be introduced in the next session of the Connecticut State Legislature to amend the statutes regulating the conduct of the offices of the county coroners in such a manner as to confer upon medical examiners the authority to order and secure the performance of autopsies in certain specified cases and also when in their opinion the cause and manner of death are uncertain.

In order to give the Council a clearer indication of what this recommendation implies, the suggested amendments of three sections of the General Statutes of Connecticut, Revision of 1930, are cited as examples:

1. Amend Section 245 by adding the phrase "or when there is uncertainty as to the cause or manner of death" after the word "others" in line 4. The first four lines of this section would then read as follows (the added words are italicized):

When a medical examiner shall have reason to suspect that the person whose body he has viewed came to his or her death by the criminal act, omission or carelessness of another or others, *or when there is uncertainty as to the cause or manner of death, he shall . . . etc.*

2. Amend section 246 by substituting "medical examiner" for "coroner" in line 1 and adding the phrase "or if there is uncertainty as to the cause or manner of death" after the word "others" in line 3. The first part of this section would then read as follows (added words are italicized):

After a view and inquiry had by the *medical examiner*, if he shall have reason to suspect that the death was caused by the criminal act, omission or carelessness of another or others, *or if there is uncertainty as to the cause or manner of death*, he may cause an examination or autopsy to be made of the body . . . etc."

3. Amend Section 262 by insertion of the words "or medical examiner" after "coroner" in line 2 and substitute the word "shall" for "may" in line 5. This section would then read as follows (added words are italicized.):

If, in any case, it shall appear to the coroner *or medical examiner* to be necessary to have a chemical or microscopic analysis or other scientific investigation for the purpose of ascertaining the cause of death of the person on whose body he is holding an inquest he shall so report to the state's attorney, who *shall* order such analysis or investigation to be made and who shall certify to the expense thereof, which expense shall then be paid by the state on an order therefor by the clerk of the superior court of such county.

The Committee realizes that further study of the statutes will be necessary to ensure precision in the wording of these suggested amendments and to make such changes in these and related statutes as will eliminate contradictions and will bring all the pertinent statutes into harmony with the conferring of this new authority upon medical examiners. As such study and revision of the language of the statutes is beyond the competence of the Committee, the Committee, in making these suggestions for verbal changes, has acted upon the assumption that the Council will refer the matter to its legal counsel and other advisers.

Submitted for the Committee.

Dec. 6, 1940

S. Bayne-Jones

Chairman

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Pavaex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

Connecticut Hospital Association

ORGANIZATION OF ADVISORY HOSPITAL COMMITTEE FOR THE CONNECTICUT PLAN FOR HOSPITAL CARE

Recently, the executives of the various member hospitals of the Connecticut Plan for Hospital Care met at the New Haven Hospital to organize the Committee of Hospital Superintendents to assist the Connecticut Plan for Hospital Care in its contacts with the various member hospitals.

James A. Hamilton, Director of New Haven Hospital, was elected Chairman of this Committee, and Richard J. Hancock, Superintendent of the Lawrence and Memorial Associated Hospitals of New London, was elected Secretary.

The state was divided into five areas geographically and representatives elected for each area. Area 1, the New Haven Area including New Haven, Meriden and Milford, will be represented by Sidney G. Davidson and James A. Hamilton. Area 2, the Waterbury Area, will be represented by Dr. B. Henry Mason. Area 3, including Hartford, Manchester, Bristol and Middletown, will be represented by Dr. Wilmar M. Allen. Area 4, including Torrington, Winsted and New Milford, will be represented by Albert W. Buck. Area 5, including Norwalk, Putnam, Willimantic and New London, will be represented by Richard J. Hancock.

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FROM THE SHARON HOSPITAL

At the Annual Meeting of the Sharon Hospital Association, Incorporated, the following officers were elected for the ensuing year. Augustus Van Cortlandt, President; Clement R. Ford, Vice-President; J. S. Chaffee, Secretary and Treasurer.

Mr. Augustus Van Cortlandt, who has been president of this hospital for twenty-five years, is seriously ill at his home in Sharon.

This hospital is rejoicing in the installation of a new and complete Kelley-Koett x-ray unit

and dark room equipment, including also a new portable outfit.

The hospital has been recipient of a unique benefit from the Amenia, N. Y. movie theater. This was a matinee, mostly for children, and everyone brought cans of groceries for the hospital kitchen. The groceries constituted the price of admission to the theater. This was a grand success and the hospital received a small truck load of provisions which are most acceptable.

The Salisbury Forum is again in successful operation this year and the total receipts from the tickets are donated to the hospital. Last year the sum of \$517.40 was realized from this source.

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FROM CHARLOTTE HUNGERFORD HOSPITAL

The Eighteenth Annual Dinner given by the Directors and Staff of the Charlotte Hungerford Hospital was held on Monday, Dec. 16 at the Conley Inn. This is in commemoration of the birth of the founder and benefactor of the hospital, Uri T. Hungerford who was born Dec. 14, 1841. The President, Francis H. Griffiths, presided and introduced as the speaker of the evening, the Secretary of the Connecticut State Medical Society, Doctor Creighton Barker. At the speaker's table were the officers of the Association, the Mayor of Torrington, the Director of the Litchfield County Hospital, Mr. Jeremiah VanBrunt and Brigadier General Sanford H. Wadhams, Chairman of the Joint Defense Committee of the State of Connecticut. The invocation was given by the Rev. James K. Brophy of Goshen and the benediction by Rev. H. Francis Hine of Torrington. Guests present numbered 110.

In 1932 the Nursing Staff of the Charlotte Hungerford Hospital modified its Christmas entertainment by giving a party for four of Torrington's neediest children. Each child was furnished with a complete outfit of clothing and was given candy, fruit and toys. This experiment was of such interest and pleasure

to the nurses that each year the idea has been continued with bigger and better parties. On December 18, 1940 eighteen children between the ages of four and ten were guests of the nurses. The party was held in the auditorium of the Nurses' Home and the children who had been selected by the welfare department of the Brooker Memorial were given a complete outfit of clothing. The boys were provided with trucks or sleds and the girls with dolls. Doctor T. L. Thomson, Chief of the Obstetrical Service of the hospital, has played the roll of Santa Claus since the beginning of this type of party. The children entertained the nurses and friends with impromptu performances in the spirit of friendly rivalry. Carols were sung by both children and adults and it is safe to say that as much pleasure was given to the nurses and their friends as to the children.

The last return from the Membership Drive of the Charlotte Hungerford Hospital Auxiliary shows an enrollment of 1158 members. It is within the realm of possibility that the total membership may total 1200 before this, the most successful drive in the history of the organization, is completed. That such a large number of individuals join the Auxiliary is highly gratifying. Among the many ways in which the organization has shown its devotion to the interest of the hospital has been in the replacement of apparatus and equipment and the extension of a redecorating project under the supervision of Mrs. William Mulcunry. Among the articles which have been replaced are drapes and slip covers for the Board of Governors' room, the nurses' living room and foyer, curtains in the sun rooms and nurses dining rooms. This committee has also been authorized to replace chairs, lamps and rugs in the dormitories.

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STATE HOSPITAL ASSOCIATION

ANNUAL MEETING

November 22, 1940

The Lawrence and Memorial Associated
Hospital, New London

The Secretary reported five meetings of the Board of Trustees were held during the second half of the year.

At the meeting of the Board held in conjunction with the special committee on compensation rates, it was agreed to recommend a rate of \$5.00 per day for all the hospitals.

This was agreed to by the majority of the hospitals. At a subsequent meeting with the insurance carriers, a counter proposal of \$4.75 plus extras was offered.

The Board has given consideration to the centralization of the annual meeting of the Association.

With the publication of the Hospital Statutes in loose leaf form, thirty-nine copies have been purchased and the Board is desirous that hospitals secure additional copies.

The Board advised the formation of an Advisory Committee to cooperate with the Connecticut Plan for Hospital Care, the committee composed of members whose hospitals are connected with the Plan.

Early in September the Board discussed with the committee of the State Medical Society relative to a plan for prepaid medical service.

Representatives of the State Board of Health appeared before the Board and outlined a development of maternal and pediatric consulting service.

The Board has been able to operate within the budget. The income from advertising makes the cost of the Association's participation in the State Medical Journal approximately \$200.00 for the year. Mr. Carl Wieler, of Grace Hospital, has accepted the position of Association Advertising Manager for the publication.

Council on Government Relation—Mr. Bartine, *Chairman*. He urged all members to keep in close touch with their representatives in Hartford in order to aid in combating any detrimental legislature during the coming session. There was discussion afterward regarding the bill to be presented at the coming legislature regarding hospital appropriations and it was voted that the questions raised by Mr. Sweeney be referred to our attorney for his advice with full authority to act according to that advice.

Advisory Committee for the Board of Nurses' Examiners. Dr. Albert Buck presented a report for the committee stating that six meetings had been held.

Hospital Insurance Policy Committee. The secretary read a report of progress from James L. Goodman, *Chairman*.

Major William B. Smith, State Medical Officer of the Selective Service, was introduced during the afternoon session of the meeting. He outlined two circulars which his office had sent to the hospitals relative to the use of diagnostic facilities and the methods for billing for this service. Following this, it was agreed that all the hospitals be urged to perform the x-ray services for fifty per cent of the rate indicated in the U.S. Civil Service Tariff, copies of which will be mailed to the member hospitals, and the laboratory procedure at a flat rate of \$3.00 per individual.

The secretary read a report of a survey on preparedness giving the number of hospitals replying and the number of beds available. It was evident that the hospitals had not definitely comprehended the questions and it was agreed that the President appoint a committee of three to make a complete survey and to cooperate with the National Committee of the American Hospital Association and with the State Committee of the Medical Society.

Committee on Uniform Compensation Charges — Dr. I. S. Geeler, *Chairman*. He reported that because of the diversity of opinion, it was advisable to await a report of the committee on extra charges. The costs of the hos-

pitals would undoubtedly increase due to the rise in commodities and the increase in salaries.

Committee on Compiling Charges — Mr. Robert Brough, Chairman. He presented the report and his committee was asked to continue their work in studying the rates and charges to townships and cities and other organizations receiving special rates.

It was voted to amend Section IV of the By-Laws as follows: Application for membership shall be made to the Secretary in writing and the applicant shall become a member after election by the Board of Trustees and upon payment of the initiation fee and dues for the first year as herein provided.

The report of the Treasurer, supported by the Auditing Committee, showed total receipts — \$3,453.56; disbursements — \$1,892.07; on hand — \$1,561.49.

It was voted that the dues to the State Association of Institutional Members shall equal the annual dues assessed by the American Hospital Association, effective 1941.

It was voted that the Association urge each of the eligible hospitals in the State to accept the rate schedule included in the Agreement for Hospital Care with the United States Federal Employees' Committee in caring for the obstetrical and pediatric consulting services.

The following officers were elected:

President — Wilmar M. Allen, M.D.

Vice-President — Anna M. Griffin

Secretary — William B. Sweeney

Treasurer — Helen T. Nivison

Board of Trustees — Sidney G. Davidson

Applications for membership reviewed and approved by the Board of Trustees:

Institutional Membership — Veterans' Home Hospital
Personal Membership — Dr. Daniel Sullivan

The meeting of the State Hospital Association on November 22nd was not only one of the best attended meetings that we have had in many years but one of the most interesting. There was a lot of healthy discussion and we need more of that sort of thing at all of our meetings. We all do not have to agree but, after discussion, we can arrive on common ground.

The address by that Master of Eloquence, the Secretary of the State Medical Society, Dr. Creighton Barker, printed in another column, contains considerable food for thought and helped to create discussion at the meeting.

There were a number of votes of appreciation recorded during the meeting but we fail to find in the minutes any such vote extended to our most efficient President and so the Editor takes it upon himself to insert a unanimous vote of appreciation and best wishes for another successful term, looking forward to a possibility for a "third term."

INDUSTRIALISTS AND DOCTORS IN JOINT MEETING

What is believed to be the first time that organized medicine has presented to organized industry a program for the promotion of industrial health on a state-wide scale, occurred in Hartford on November 19, 1940, at the offices of the Manufacturers Association of Connecticut. Colonel Fred U. Conard, Vice Pres., Underwood Elliott Fisher Co., Hartford, presided at the meeting.

The proposal, presented by Doctor Clifford Kuh, New Haven, on behalf of the Society, discussed the objectives, functions and organization of industrial medical service. An inquiry form to be sent to the 900 members of the Manufacturers Association, representing 95 per cent of the industrially employed population of the state, aims not only to survey existing medical facilities but to elicit from manufacturers requests for information or service in inaugurating or expanding medical service at their plants. A particular purpose is the conservation of man power under the national preparedness program.

The plan, which will be modified to conform to suggestions made at the meeting, will be published in detail in an early issue of the Journal.

Mr. E. Kent Hubbard, President of the Association, greeted those present and stressed the opportunity to make Connecticut the healthiest state in the Union for the industrially employed. Also representing the Association at the meeting were Messrs. C. L. Eyanson, Executive Secretary, and Paul W. Adams.

Representing the manufacturers were: Messrs. D. G. Phelps, Vice Pres., Colt's Patent Fire Arms Co., Hartford; Franklin Farrel, 3rd, Farrel-Birmingham Co., Ansonia; Carrol B. Knibbs, American Brass Co., Waterbury; Eugene F. Murphy, Pratt & Whitney

(Concluded on Page 72)

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

Medical Preparedness

ORGANIZATION OF GENERAL HOSPITAL NO. 39

James C. Fox, Jr., M.D.,
New Haven, Conn.

During the first world war the Yale School of Medicine organized MOBILE HOSPITAL NO. 39 under the inspiring leadership of Doctor Joseph M. Flint. The original strength of the command was fifteen medical officers, nineteen nurses and eighty enlisted men. This mobile surgical unit sailed for France on August 23, 1917, played an important role during the St. Mihiel offensive, and during its entire career served as a model for this type of surgical organization functioning close behind the lines. The officers of this unit with grades at time of organization were as follows:

Lieut. Arthur B. Dayton
Lieut. Robert L. Elliston
Major Joseph M. Flint
Lieut. Francis B. Jennings
Lieut. William H. Morriss
Lieut. Alexander L. Prince (deceased)
Capt. Alfred M. Rowley
Lieut. George M. Smith
Capt. J. W. Squires (deceased)
Lieut. Edward C. Streeter
Capt. Philemon E. Truesdale
Lieut. Donald B. Wells

Last spring the War Department proposed that Yale sponsor a similar surgical unit in the present national emergency to be mobilized in case of war. However, it was felt by Dean Bayne-Jones and other members of the faculty, that a much larger general hospital might be organized by the School of Medicine in view of the growth of the New Haven Hospital and expansion of the clinical services which have taken place during the past twenty years. Permission was granted by the Surgeon General last July to form a General Hospital which has happily been designated No. 39.

The War Department has authorized the organization during peacetime of around fifty such regular army inactive units through their affiliation with selected civil institutions. The Reserve officer personnel is assigned during

peacetime; all other personnel is procured during actual mobilization. The Administrative service consists of 18 commissioned officers of which the Commanding Officer of the unit is assigned from the Medical Corps of the Regular army with rank of Colonel. The professional service is comprised of 48 commissioned officers of the Medical Reserve Corps and 7 of the Dental Reserve Corps. These 55 reserve officers are assigned by the sponsoring institution to fill the different ranks, according to the table of organization specified by the War Department. A senior reserve officer is designated as Unit Director and is responsible for peacetime organization of the unit.

In addition to the 73 commissioned officers the unit contains 120 nurses and 500 enlisted men of the hospital corps. Besides the military personnel the services of 20 civilians is also required in the care of the thousand patients which a general hospital is designed to provide for.

The War Department does not at present contemplate mobilizing any of the affiliated units during the current emergency, but only upon the declaration of war. In such case the hospital would presumably be located in the general theatre of operations. In the unprecedented scope of modern mechanized warfare and wide latitude of aerial bombardment, the traditional concept of "the rear of the combat zone" obviously has little meaning.

Since the first of last August when Doctor Blake, Acting Dean of the Medical School, first informed the staff of this project, the response has been most enthusiastic. Volunteers have outnumbered the positions available. Preferment was naturally given those men who already held commissions in the medical reserve corps. In the recommendation for appointment care has necessarily been taken not to deplete the school of essential teaching services. The problem of selection of personnel to fill the various posts calling for specialized training and clinical experience has been a considerable one. However, an attempt has been made to provide a place for every applicant

who expressed a keen desire to join the unit.

Although the nurses in the unit will be actually procured during mobilization, the personnel may be tentatively selected during peacetime from the enrollment in the American Red Cross Nursing Service for service in the Army in emergency. This selection is also in progress under the direction of Dean Taylor of the Yale School of Nursing. Over 80 graduates from the Yale School of Nursing and various affiliated hospitals in the state have already expressed their willingness to serve in the unit.

The following is a list of those who have been recommended for commission in the Reserve Corps with special assignment to General Hospital No. 39. Various other candidates are either in the process of physical examination or have not yet reached final decision on enlistment or assignment. Unless otherwise noted the members reside in the New Haven district.

MEDICAL SERVICE

Lieutenant Colonel: Dr. James C. Fox, Jr. (Unit Director).

Majors: Dr. Charles A. Breck, Wallingford
Dr. John H. Bumstead.
Dr. Clarence L. Robbins.
Dr. Lloyd J. Thompson.
Dr. James D. Trask.

Captains: Dr. Edward A. Abbey.
Dr. Warren T. Brown.
Dr. Daniel B. Hardenbergh, Bridgeport.
Dr. Robert H. Jordan.
Dr. Gerald Klatskin.
Dr. William J. Bruckner.

First Lieutenants: Dr. Robert A. Hettig.
Dr. William L. Peltz.
Dr. Jack D. Rosenbaum.

SURGICAL SERVICE

Lieutenant Colonel: Dr. Ashley W. Oughterson.

Majors: Dr. L. N. Claiborn.
Dr. Lewis C. Foster.
Dr. Edward J. Ottenheimer, Willimantic.
Dr. Francis A. Sutherland, Torrington.

Captains: Dr. Jachin B. Davis.
Dr. Marvin L. Latimer.
Dr. William S. Perham.
Dr. Max Taffel.
Dr. Kenneth W. Thompson.
Dr. Frederick A. Wies.

First Lieutenants: Dr. Joseph A. Fiorito.
Dr. Paul J. Laube.
Dr. Henry Merriman.
Dr. J. Karl Poppe.
Dr. Frederick A. Post.

DENTAL SERVICE

Captains: Dr. Wilbur D. Johnston.
Dr. Walter S. Langston.

First Lieutenants: Dr. William M. Levine.
Dr. William R. Dunleavy.

LABORATORY SERVICE

Major: Dr. Harry M. Zimmerman.

Captain: Dr. Joseph F. Sadusk, Jr.

First Lieutenant: Dr. Louis G. Welt.

ROENTGENOLOGICAL SERVICE

Major: Dr. Michael D'Amico.

Captain: Dr. Willard E. Buckley, Middletown.

First Lieutenant: Dr. Ralph J. Littwin.

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9,100 DOCTORS WILL BE REQUIRED FOR THE U.S. ARMY BY NEXT SPRING

A total of 9,100 physicians, of whom 5,300 must be procured during the next few months, will be required for the total strength of the army of the United States next spring, which will be approximately 1,400,000 men, the surgeon general of the Army declares in an outline regarding the participation of the Army Medical Department in the 1940-1941 military training program.

The surgeon general says that the 1,400,000 men will represent a Regular Army of 400,000 officers and men, the National Guard of the several states federalized as the National Guard of the United States, numbering 200,000, and citizens selected for military training during the coming twelve months — about 800,000 in number.

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MODIFICATION OF PHYSICAL STANDARDS FOR SELECTIVE SERVICE

A circular recently issued by the chief of staff of the U.S. Army on the modification of physical standards under Selective Service reveals that men will no longer be considered suitable for military service if they have malaria, hookworm, nutritional diseases, certain blood diseases, or remediable incapacity due to recent acute illness or injury or to employment or environment in civil life.

Beriberi, scurvy and other nutritional deficiencies, if remediable by correction of diet and not severe, will no longer be considered as

conditions which would permit general military service, the circular says. Likewise men are disqualified if they have secondary anemia (anemia due not to disease of the blood making organs but to some other previous disease or injury), purpura (purple patches on the skin and mucous membranes due to the escape of blood into the tissues beneath the skin), sickle cell anemia (an anemia accompanied by ulcers and characterized by the red blood cells acquiring a sickle-like shape in the test tube) or malaria.

These defects, the circular explains, "will be regarded as causes for rejection by Army medical examiners until there has been recovery without disqualifying sequelae. Medical examiners will reject all men who by reason of physical defects are considered unfit for early participation in training activities."

* * * *

CORRECT DIAGNOSIS OF HERNIA IMPORTANT IN DRAFTED MEN

Pointing out that the presence of a hernia in men of selective service age is a deterrent to military service, Stephen A. Ziemann, M.D., Chicago, declares in *The Journal of the American Medical Association* for Nov. 30 that the widespread prevalence of this condition in men of this age group necessitates a correct understanding on the part of the physician as to what constitutes a hernia.

Dr. Ziemann says that an impulse perceptible on coughing or straining while the examining finger of a physician is in the external inguinal ring (a ringlike structure formed in the groin by firm bands of fiber) cannot be safely accepted as diagnostic of a hernia. He believes that the placing of the first, second and third fingers over the inguinal (groin) region in such a manner that the index finger rests on the so-called weak spot is a more effective diagnostic method and is particularly helpful in borderline cases. Findings at the operating table have shown the method to be effective, he says. He also declares that straining is a better method for eliciting the essential diagnostic factor than is coughing.

- NEWS -

from County Associations

Fairfield

The annual election of officers of the Bridgeport Medical Society was held on December 3 with the following elections: John Maxwell, President; Ellwood C. Weise, President-Elect; Owen Groark, Vice-President; Joseph Watts, Secretary; James McManus, Treasurer. The paper of the evening was given by Doctor E. Burke, Chief Surgeon at the Medical Center, Jersey City, on the subject of Traumatic Abdominal Surgery. Doctor Burke gave some interesting case reports and showed some remarkable colored slides, in the preparation of which he was his own artist.

Plans are now being made for the annual health week from February 17 to 23 under the chairmanship of Doctor George Buckhout. In the past this has consisted of addresses before church groups, service groups and P.T.A. associations by members of the local medical society.

The November Clinico-pathological Conference of the Stamford Hospital staff heard a very interesting report of a case of dermatomyositis. The clinical picture, together with a review of the literature, was ably presented by Leo M. Smith of the hospital's associate staff. Rudolf Colmers of the resident staff gave a detailed report of the necropsy findings.

According to an announcement of the building committee, ground for the proposed St. Joseph's Hospital will be broken on March 19, 1941.

Dr. John E. Sullivan, attending surgeon at the Hospital for the Ruptured and Crippled, and Bellevue Hospital, addressed the December meeting of the Stamford Medical Society. His paper, "The Treatment of Fractures of the Lower Extremities in Children", proved very interesting and was well received by the members of the society.

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Hartford

Doctor Ralph M. Tovell of Hartford (with Doctor Charles B. Hinds, Jr.) read a paper on

"Abdominal Block with General Anesthesia for Upper Abdominal Surgery" before the Session on Anesthesia, American Medical Association, in New York City last June. The paper was published in the Journal of the American Medical Association, November 16, 1940.

Doctor Donald B. Cragin, Medical Director of the Aetna Life Insurance Company and a resident of Hartford, was elected president of the Association of Life Insurance Medical Directors at the annual meeting held recently in Boston.

On December 2, Doctor Charles C. Lund, Assistant Professor of Surgery at Harvard Medical School, addressed the Hartford Medical Society on "Vitamin C in the Normal and in Surgical Patients." Doctor Lund gave a detailed lantern slide demonstration of the research work on a volunteer medical student who was deprived of vitamin C for many months but after resuming the administration of vitamin C showed no ill effects. This experimental work formed the basis for hours of studies of the effects of vitamin C in surgical patients. The paper was discussed by Doctor Louis P. Hastings. Preceding the evening meeting—Doctor Lund conducted a clinic at the St. Francis Hospital at which two surgical problems were discussed.

The annual meeting of the Hartford Medical Society will be held on January 6 at 8:30 p.m. with the annual social festivities to follow the election of officers and the address of the retiring president.

* * * *

Middlesex

On the evening of Dec. 5, 1940 at Higgins Inn, Middletown, there was a large representation of the doctors of Middlesex County to bid farewell to Doctor George Elliott who is assuming the superintendency of Brattleboro Sanatorium in Vermont. Doctor Carl C. Chase was toastmaster and responses were given by Doctors Leak, Waterman and Beauchemin. On behalf of the group, Doctor F. E. Tracy presented to Doctor Elliott a traveling bag. Following conclusion of the formal meeting a number of the doctors remained to pit their respective skills against Doctor Elliott's in games of chance. It must be noted that

they again, though this time reluctantly, contributed to his material well being.

Doctors Sweet, Craig and LaBella were the speakers at the December meeting of the Central Medical Association. They reported on their impressions of the October meeting of the American College of Surgeons.

* * * *

New Haven

Doctor James C. Hart, formerly assistant epidemiologist in the New Haven Department of Health, has been a member of the Bureau of Communicable Diseases, State Department of Health, since September 1, 1940.

Doctor A. J. Mendillo of New Haven presented a paper on "Surgery of the Gall Bladder" and participated in a symposium on "Carcinoma with Special Reference to the Lungs" at the first Guild meeting of the State of Maine of the United States Chapter of the International College of Surgeons held at Poland Springs last summer.

Doctor Harold M. Marvin of New Haven addressed the Annual Scientific Assembly of the Medical Society of the District of Columbia at its meeting in Washington in October. The Assembly took the form of a postgraduate course in cardiovascular-renal disease and Doctor Marvin's subject was "Diagnostic Criteria of Coronary Artery Disease."

Doctor Frederick N. Sperry and Mrs. William Newton Parker were married on December 7, 1940 at New Haven.

* * * *

New London

On November 7 the monthly meeting of the New London Medical Association held at Uncas-on-the-Thames was devoted to a program on national defense. Speakers were Mr. Elmer Farnham, Director of the Norwich Draft Board; Major John Carter, U.S.A. Officers Reserve; Miss Agnes Ohlson who discussed nursing activities; and Doctor George M. Smith who discussed the medical preparedness program and its developments to date.

The next meeting of the Association occurred on December 5, also at Uncas-on-the-Thames, and was addressed by Doctor Frank Pemberton of Boston on "Pelvic Infections." Discussion

was led by Doctor James Raglan Miller of Hartford.

Major Savage will soon leave for Florida to join the National Guard unit. Draftees are being examined rapidly by both the New London and the Norwich boards.

Coming programs of the New London County Medical Association include a meeting on January 2, subject "Pneumonia and Chemotherapy" speaker Doctor Jesse Bullowa, New York City; February 5, symposium on "Acute Abdominal Pain," speakers to be announced later.

Doctor Jack Sabloff, who was engaged in the practice of pediatrics in New London for about two years, has accepted a civil service position. He was ordered to report to a U.S. Veteran's Facility in Georgia.

Maynard Brandsma, an interne at the Lawrence & Memorial Hospital in 1939, is practicing internal medicine in Los Angeles, California.

Doctor J. E. Fuchs, another 1939 interne at the Lawrence & Memorial Hospital, is at the Veteran's Hospital, Sawtelle, California. He is on the staff of the Los Angeles County Hospital and has a teaching position in internal medicine at one of the Los Angeles medical colleges.

Doctor Maurice Spottswood, an interne at the Lawrence & Memorial Hospital, 1936, has opened an office for the practice of neurology and psychiatry at Tulsa, Oklahoma. Doctor Spottswood was educated in the public schools of New London and is a graduate of Georgetown Medical College. After completing his internship he was connected with the Connecticut State Hospital for the Insane in Norwich, and recently he was connected with the Neuropsychiatric Institute of the Hartford Retreat.

* * * *

Windham

The Windham County Medical Association met in Danielson on October, 1940. The agenda was largely devoted to the presentation of the medical preparedness program in Connecticut by Doctor George M. Smith, chairman of the State Medical Society Committee. Doctor James C. Fox, Professor of Neurology at Yale, delivered an interesting address on

some of the commoner neurological problems confronting the general practitioner. Doctor Andrew Laakso of Danielson was admitted to full membership in the Association.

-The- General Practitioner's Forum

Recently, at an informal Scouters meeting, we were backed into a neutral corner and subjected to a thorough cross-examination on the whys and wherefores of certain medical practices. The chief item of interest was the validity and importance of a Doctor's certificate of disability; the questioners were a factory personnel manager and a school principal. We stood our ground with suitable professional dignity and observed that such a certificate should be taken at face value by the layman; for it is issued only after due consideration of available facts. Moreover, it must be judged by equally professional standards. The argument was sound enough but the evidence produced was overwhelmingly against it. The personnel manager said he could — (and did) — produce 50 certificates of which 12 were proven authentic. The biggest offender and one that invariably appeared every month when the shifts changed was, to wit, "Mr. John Doe is unable to work nights because of a chronic conjunctivitis induced by working under bright lights." There were other reasons given for inability to do night work, however, a little investigation would have shown the doctors that the factory used artificial lighting almost 24 hours a day and that working conditions were the same for all shifts. There were others covering variable periods of illness. Private investigation by the management showed that many were merely to cover up a vacation trip. The school principal produced a few that could reasonably be called doubtful due to a mistaken diagnosis. The main offenders here were scabies, impetigo and scarlet fever. However, he produced many that were palpably issued to satisfy a parent's request. These were cer-

(Concluded on Page 67)

SPECIAL NOTICES

POSTGRADUATE COURSE IN AVIATION MEDICINE

The George Washington University School of Medicine announces its second annual postgraduate course in Aviation Medicine including Aviation Ophthalmology for graduates in medicine. The course will be held February 3 to 7, 1941, inclusive, and will include lectures by medical officers of both the U. S. Army and U. S. Navy as well as prominent medical aviation authorities from various parts of the United States and members of the faculty of the George Washington University School of Medicine. The fee for the course will be \$25.00, \$15.00 payable with registration. Registration should be made with the George Washington University School of Medicine, 1335 H. Street, N. W., Washington, D. C.

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PHYSICIANS FOR THE NAVY

Physicians are needed in the Regular Navy and the Naval Reserve.

Regular Navy: Applicants must be under thirty two years of age and have completed one year's internship. They are commissioned as lieutenant (junior grade) and paid \$2,699 per year if having no dependents, or \$3,158 per year if having dependents.

A limited number of **FOURTH YEAR MEDICAL STUDENTS** are admitted on acting appointments, with the same pay, given one year's internship in the Navy after graduation, and then commissioned.

The next examination for both these classes will be held on January 6, 1941. Applications must be submitted early in December.

Volunteer Naval Reserve: Members are not subject to the Selective Service Draft but obligate themselves to serve in time of war or National emergency. If they request it, they may be given active duty at other times.

There are two classes of the Volunteer Reserve:

(A) **VOLUNTEER GENERAL SERVICE CLASS:** Applicants must be under thirty five years of age. They are commissioned as lieutenant (junior grade) — (equal to 1st Lieutenant in the Army) or, if of sufficient age and experience, as lieutenant — (equal to Captain in the Army). Many will be given aviation training at government expense, if they request it. **INTERNES** and **RESIDENTS** are eligible to enroll in this class of the Reserve.

The Surgeon General places all internes and residents on the deferred list and they will not be called to active duty before finishing their internship or residency except in extreme urgency.

(B) **VOLUNTEER SPECIAL SERVICE CLASS:** This class is composed of doctors who have had special training and are under fifty years of age. A limited number of general practitioners are also commissioned in this class. The rank is lieutenant (junior grade), lieutenant, or lieutenant commander, dependent upon age, professional standing and academic seniority. If mobilized, they would be assigned to special service within the United States or its possessions or on hospital ships.

For further information apply by letter, telephone, or call in person at the District Medical Office, Headquarters Third Naval District, Federal Office Building, 90 Church Street, New York City.

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AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

In accordance with its Articles of Incorporation, the American Board of Obstetrics and Gynecology has elected Dr. Norman F. Miller of Ann Arbor, Michigan, and Dr. Willard R. Cooke of Galveston, Texas, as members, directors, and examiners, to fill the unexpired terms of Dr. Jennings C. Litzenberg and Dr. Grandison D. Royston, both of whom resigned on October 15, 1940. These replacements make a total of four changes in personnel on the Board during the past three years.

* * * *

EXAMINATION — AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The written examination and review of case histories (Part I) for Group B candidates will be held in the various cities of the United States and Canada on Saturday, January 4, 1941, at 2:00 P.M. Formal notice of the place of examination will be sent each candidate several weeks in advance of the examination date. No candidate will be admitted to examination whose examination fee has not been paid at the Secretary's Office. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held in June 1941.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, from May 28 to June 1, 1941, immediately prior to the opening of the annual meeting of the American Medical Association.

Application for admission to Group A, (Part II) examinations must be on file in the Secretary's Office not later than March 15, 1941.

After March 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

The Board wishes to announce a modification of the case record ruling (effective January 1, 1942) as it appears in the September 1940 issue of the Board booklet. This ruling should read: "It is preferable that the number of residency cases submitted should not be more than half (25) of the total number of fifty (50) cases required."

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

MISSISSIPPI VALLEY MEDICAL SOCIETY 1941 ESSAY CONTEST

The Mississippi Valley Medical Society offers annually a cash prize of \$100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society at Cedar Rapids, Iowa, Oct. 1, 2, 3, 1941, the Society reserving the exclusive right to first publish the essay in its official publication — the MISSISSIPPI VALLEY MEDICAL JOURNAL (incorporating the RADIOLOGIC REVIEW). All contributions shall not exceed 5000 words, be type-written in English in manuscript form, submitted in five copies and must be received not later than May 1, 1941. The winning essay of the 1940 contest appears in the January, 1941 issue of the MISSISSIPPI VALLEY MEDICAL JOURNAL (Quincy, Ill.) Further details may be secured from

Harold Swanberg, M.D., Secretary,
Mississippi Valley Medical Society,
209-224 W.C.U. Building, Quincy, Illinois.

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SITUATION WANTED

Doctor Clarence E. Burt, a member of our Clinical Congress Committee and a practicing physician in New Bedford, Massachusetts, is interested in placing a medical secretary-technician. She is very highly recommended by Doctor Burt. For further information write Medical Secretary-Technician, care of *Connecticut State Medical Journal*, 58 Church Street, Hartford, Conn.

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PREPAREDNESS PROGRAM TODAY

(Continued from Page 36)

held aloof from the intrigues and aggressive plots of statesmen. He conquers empires by saving lives, not wasting them, and his heart is slow to respond to the maudlin patriotism that impels the mass. Although he is the first to go when it starts and the last to come back when it is over and he patches up friend and foe with fine impartiality, he is reluctant to take his scalpel and his skill and sally forth to war for he knows the futile tragedy of it. Medicine is always on the battle front of life, waging war on the enemies of mankind, not on man; its creed is peace and good will."

GENERAL PRACTITIONER'S FORUM

(Continued from Page 65)

tifications of inability to do gymnasium work due to some physical or emotional upset. Inquiry usually showed the reason was the disinclination of the child duly supported by the parents. These are only a few examples culled from a relatively small group and area, but they seem to indicate a growing skepticism in the 'To Whom It May Concern.' It would be interesting to know if other men have had the same experience.

Allen of Knickerbocker and Bellevue Hospitals reviewed a series of 2500 cases of head injuries in children. Incidence was 2 to 1 in relation to other trauma. Pertinent items from the paper are outlined. 55% had clinical signs of fracture, less than half of which could be proved by x-ray; 34% had cerebral concussion; 10% had brain injury; 1% were unclassified. Treatment was conservative. All lacerations were carefully cleansed and examined, then sutured without drainage. Fractures were treated expectantly; pulse recorded every 15 minutes and is an important symptom. Fluids were limited and the head kept elevated at 45%. Lumbar puncture is unnecessary and used only in the exceptional case. Prevention of infection is important and especially so when the fracture involves the anterior and middle vaults. Prognosis was good if the child lived 24 hours and was no worse at the time; if improved in 24 hours it was excellent. Most deaths occur in the first 24 hours (80%). Later deaths are usually due to infection. Fractures through potentially infected areas are always dangerous and the prognosis is poor. Injuries to the middle meningeal artery were rare, only two cases were found and both were fatal. Recovery is usually complete. Headaches, dizziness and changes in mentality and personality occasionally occur but many of them were completely cured after legal and financial settlement. King in the *New York State Journal of Medicine* for April 1:40 recommends the use of strontium bromide, 15 grains dissolved in 10cc. sterile distilled water and given intravenously in severe cases of asthma. The action is more prolonged than of adrenalin and just as prompt. He has had no untoward symptoms.

T. P. R., M.D.

• OBITUARIES •



OLIVER THOMAS OSBORNE, M.D.
1862-1940

Doctor Oliver Thomas Osborne died at his home in New Haven on November 11, 1940. Among the bearers at his funeral were Doctors Edward P. Allen, Charles J. Bartlett, D. Chester Brown, B. Austin Cheney, James F. Cobey, Charles T. Flynn, David R. Lyman, Stanley H. Osborn, C. Seaver Smith, William F. Verdi, and M. C. Winternitz. Doctor Osborne's death, in his seventy-eight year, brought to a close a lifetime devoted to the study and practice of medicine, to the teaching of medical students, and to the organization of medical aid to the tuberculous sick of the state.

Doctor Osborne was born in New Haven on November 14, 1862. His father was Oliver Stuart Osborne and his mother was Ellen Lewis Sturges. He came from a long line of colonial ancestors on both his mother's and father's side. He accomplished his last year in the New Haven High School concurrently with his first year of the three year course in the Yale Medical School, so that he received his degree of M.D., in 1884 at the age of twenty-one, two years after graduating from the High

School. This was a sample of the perseverance which characterized his life. He was given the degree of M.A. at Yale University in 1899. Among his classmates were Doctor D. Chester Brown and the late Henry L. Swain. The year of 1884-85 he and Doctor Swain spent in the clinics at Leipzig, Germany. Their work there had a profound influence upon the professional careers of both of these men. They acquired a taste for investigation and a capacity for thoughtful observation. Doctor Osborne began the practice of medicine in New Haven in 1886. In 1888 he was an assistant in the Medical Clinic of the New Haven Dispensary, and was Chief of the Medical Clinic from 1890 to 1911. As a natural sequence of his teaching medical diagnosis and therapeutics in the Dispensary he occupied the following positions on the faculty of the Yale Medical School: Instructor in Materia Medica and Therapeutics 1891- ; Assistant Professor of Materia Medica and Therapeutics 1892-95; Professor of Materia Medica and Therapeutics 1895-1911; Professor of Materia Medica, Therapeutics and Clinical Medicine 1906-11; Professor of Therapeutics 1911-25; Professor of Therapeutics, Emeritus, 1925-40.

Doctor Osborne was an investigator and a crusader. He was scornful of the prescription containing many drugs and of the so-called elegant pharmaceuticals. He taught his students to write a prescription for one or two drugs only, always having in mind the physiological action of the drugs used and the results aimed for. Although Doctor Osborne was a clinician in the broadest sense, he was most interested in the diseases of the chest. Incipient pulmonary tuberculosis, the various types of pneumonia, and diseases of the heart were carefully studied by him. His consultation practice with his colleagues was extensive, so that he achieved eminence as a heart specialist. In 1901 at a meeting of the County Medical Association he called attention to the necessity for a hospital for tuberculosis patients in New Haven County. Largely through his efforts the Gaylord Farm Sanatorium Tuberculosis Association was formed. The early organization meetings were held in his office. From this beginning until lately he was a Director and Chairman of the Medical Board of this institution. He was a promoter of an act of the Connecticut Legis-

lature that organized in 1909 a State Commission on Tuberculosis, which Commission has developed five state sanatoria for the care and treatment of tuberculosis. Through the efforts of the New Haven County Anti-Tuberculosis Association and through the efficient work of the State Tuberculosis Commission tuberculosis in Connecticut has decreased 70%. Through the energy of Doctor Osborne the Pure Food and Drug bill was passed by the Connecticut Legislature in 1907. In 1914 he spoke before the New Haven County Medical Association of the dangers of mouth infection and asserted that many of the infections of the human body had their source in teeth infections. The hostile criticism of his assertion at this meeting seems ridiculous today when his conclusions are universally accepted by the medical and dental professions. His curiosity was stimulated when he discovered his first case of acromegaly. He studied the scanty literature of the day, — only two cases of acromegaly had been described in this country, — made the diagnosis, and presented his patient before several medical societies. He wrote the article on acromegaly in Buck's Handbook of the Medical Sciences in 1900. The skeleton of this patient was prepared and articulated, by the late Professor Ferris and is now in the museum of the Yale School of Medicine. His next investigation was in the functions of the thyroid gland and its hypo and hyper states, concerning which he wrote many articles which were accepted as authoritative. It is small wonder that the subject of the endocrine glands next challenged his restless curiosity. Endocrinology became his major interest in his later life.

He was a clear thinker and his deductive faculties were well trained. It is not surprising that he became a voluminous writer on many subjects on medical and public health subjects. The diversities of his interests are revealed in the titles of some of his books and papers: Principles of Therapeutics (1921); Handbook of Therapy, 9th Edition, (1938); Introduction to Materia Medica and Prescription Writing (1900); Acromegaly, Buck's Reference Handbook; Treatment of Typhoid Fever, International Clinics, 12th Series; Organotherapy, Cohen System of Physiological Therapeutics, Volume XI, 1905; Introduction to

Materia Medica and Pharmacology (1906); Therapeutic Section of the Journal of the American Medical Association 1907-1919; Prevention and Treatment of Infections (1915); Disturbances of the Heart, 3d Edition (1925); Disturbance of the Kidney (1917); Health, What Everyone Ought to Know (1929); Mouth Infection (1934); The Evaluation of Symptoms (1935), and more than 100 articles on medical subjects, among which are twenty articles on endocrinology, twenty-five on mouth infection, a number on medical education and the teaching of therapeutics, several on the United States Pharmacopoeia and what it should contain.

Of late years he has done intensive work in the field of stomatology. In 1933 the American Society of Stomatologists, at its annual meeting, awarded him the Chompret prize "for his meritorious contributions to the science of stomatology and for his untiring labors to bring dentistry and medicine to a plane of better understanding and appreciation of their common problems for the good of mankind." Doctor Osborne was an Honorary Fellow of the American College of Stomatologists, a member of the International Society of Stomatologists, a member of the American Medical Editors and Authors Association, Honorary Member of the Association for the Study of Internal Secretions, Fellow of the American College of Physicians since 1923, and Governor for Connecticut of that organization from 1924 to 1931. He was a member of the American Medical association, Connecticut State Medical Society, New Haven County Medical Association (President 1899), New Haven City Medical Association (President 1910), Connecticut Academy of Arts and Sciences, and the New Haven Historical Society. He was one of the founders of the National Tuberculosis Association; Chairman of the Section on Materia Medica and Therapeutics of the American Medical Association (1904); Member of the Council on Pharmacy and Chemistry (1910-16); Vice-President of the United States Pharmacopoeial Convention and Member of the Revision Committee of that body (1910-20). He was a member of the American Therapeutic Society (President 1905). During his active years Doctor Osborne was a member of the Graduate, the Union League, the Quinnipiac, and of the

New Haven Country Clubs. Doctor Osborne was a Mason and a member of the Medical Board of the Masonic Charity Foundation. Politically he was a Republican, and his religious affiliation was with the Protestant Episcopal church. He found recreation in writing and in travel. He was married in New Haven on April 18, 1888, to Mary Woodward, daughter of Ami Tyler, and had one child, Marguerite Nichols Osborne, born January 23, 1899.

At the age of three Doctor Osborne was stricken with infantile paralysis, which left him permanently lame so that he always needed a cane. Such a handicap was most serious for an active physician. It did not, however, limit his industry in the clinics or in making domiciliary visits to his patients. This affliction never dampened his enthusiasm for work. Again in his sixties he suffered much from asthma, which did not prevent him from continuing his writing but did at times interfere with his office consultations. During his last years he studied his own case with his usual care and left behind him his own bedside record, symptoms, remedies used, and the results. He never left his house during the last nine years of his life.

All in all, Doctor Osborne accomplished much. The good which he did cannot be calculated. He became preeminent in his profession. He did much for the Yale School of Medicine and for the medical profession. He was gentle and considerate to his patients. He was good to the sick poor. He was courteous and helpful to his colleagues, especially to the young doctors. He was a fine gentleman of the old school. His life of self-sacrifice, of industry, of thought, and of devotion to his work is a lesson to all of us.

B. Austin Cheney, M.D.

* * * *

JOHN CRANDALL LINDSAY, M.D. **1883-1940**

Doctor John Lindsay died in the New Haven Hospital November 16, 1940 following an operation for gastric ulcer. He had been in

failing health for several months, yet carried on with magnificent courage and an indomitable will.

John Lindsay was born November 22, 1883 in Portland, Maine, the son of a Methodist minister. He received his A. B. degree from Colby College in 1906, and his medical degree from Harvard in 1910. Following his graduation he interned at the Massachusetts State Infirmary. From then until he took up his residence in Cheshire he had extensive training and many interesting experiences. He spent two years as Assistant Physician in the State Hospital at Augusta, Maine, three years as Senior Assistant Physician in the mental department at the Massachusetts State Infirmary, also spent some time as Senior Physician in the Worcester State Hospital. In 1918 he entered the United States Navy as a medical officer and served as a Lieutenant. At the end of the war he became Assistant Superintendent in the Norfolk County Tuberculosis Hospital, South Braintree, Massachusetts. From 1921 until 1925 when he came to Cheshire as Resident Physician at the Cheshire Reformatory, he served as Senior Physician in the Boston State Hospital.

Doctor Lindsay was a member of Temple Lodge in Cheshire, Triune Chapter in Southington, the National Sojourners, the Connecticut State Medical Society, American Medical Association, the New England Society of Psychiatry, the American Psychiatric Association and the American Prison Association.

Those of us who were fortunate in knowing Doctor Lindsay feel his loss most keenly. He was of modest nature, a brilliant conversationalist with a wealth of medical and psychiatric knowledge, an outstanding figure in the community. He leaves a host of friends.

He married Marie Strom in August 10, 1914. Mrs. Lindsay had received her degree of Doctor of Medicine at Tufts in 1911. He is survived by his wife and a son, John, who is a student at Washington and Jefferson College.

William John Moore, M.D.



•Quarto Notes•

METHODS FOR DIAGNOSTIC BACTERIOLOGY

by

Isabelle G. Schaub, A.B.,

Assistant in Bacteriology, Johns Hopkins University
School of Medicine

M. Kathleen Foley, A.B., Bacteriologist

In Charge of Diagnostic Bacteriology Laboratory of
Medical Clinic, Johns Hopkins University
School of Medicine

313 pages

\$3.00

St. Louis C. V. Mosby Co. 1940

A three hundred page compendium of bacteriological procedures written by two members of the bacteriological staff of John Hopkins University Hospital and School of Medicine.

The anlage of the volume was an outline of methods for the use of transient workers in the laboratories of the authors — internes and medical students, who though possessed of a background in the subject lacked practical experience.

The book is divided into three sections. Part One explains in detail the handling of various biological samples as they are presented for bacteriological diagnosis, from the choice and mode of inoculation of media, conditions of culture, through a day by day routine for the identification of the organisms.

Part Two deals with the serological identification of organisms, and the detection of agglutinins in the patient's serum. Here again the account takes one, step by step, through those tests that are of practical import. A brief discussion of the interpretation of results is included.

In the last section is found the formulae and directions for use of the media, stains, and reagents used in the previous procedures.

The book is limited to medical bacteriology of practical importance. The material is succinctly presented, and sprinkled with helpful suggestions rarely found in the ordinary text. Every other page is a blank for the addition of notes on new methods or alterations in those suggested—a thoughtful addition that should prolong the usefulness of the volume.

There is no attempt made to enter into any theoretical considerations. No illustrations are offered. Its expressed purpose is to serve as a guide for the inexperienced worker. A valuable little volume in any laboratory, and especially so in one utilizing a transient personnel.

J. Coll

TABER'S CYCLOPEDIA MEDICAL DICTIONARY INCLUDING A DIGEST OF MEDICAL SUBJECTS.

by

Clarence Wilbur Taber and Associates

1486 pages

273 illustrations

Philadelphia

F. A. Davis, Co.,

1940

This dictionary is a new publication containing over twice as many pages as the previous edition. It includes between 50,000 and 60,000 words, only a few thousand less than the vocabulary of the large unabridged medical dictionaries. Some twenty new features, not found in other competitive medical dictionaries are represented, including 273 illustrations.

The principal author and editor-in-chief is well known to countless educators and students as his textbooks have been in use for many years in colleges, secondary, and elementary schools from coast to coast. Associated with him are twelve physicians, one pharmacist, and one nurse, all connected with medical schools or hospitals in and about Chicago.

The volume is well printed and bound and contains an alphabetical thumb index for the convenience of the reader.

* * * *

THE ERA KEY TO THE U.S.P. XI— N.F. VI.

by

Lyman D. Fonda

Professor of Pharmacy, Brooklyn College of
Pharmacy

320 pages

New Edition (5th)

\$1.00

Newark, N. J.

Haynes & George Co.

1939

This very handy volume contains all the essential information of the latest editions of the U. S. Pharmacopoeia and the National Formulary in a pocket book with these five new features:—

Key to Non-Official Materia Medica

Table of Doses

Incompatibilities

Pharmaceutical Latin Dictionary

Glossary of Medical Terms

For 48 years the Era Key has been a favorite prescription handbook among physicians and pharmacists. This new edition has been thoroughly revised and edited by Professor Fonda.

It is not anticipated that Era Key will replace the U.S. Pharmacopoeia or National Formulary, but serve as a handy, reliable reference, an aid to students of pharmacy and medicine and to physicians and pharmacists in intelligent prescribing and dispensing.

LISTEN TO A FOETAL HEARTBEAT

— through the new "two-channel" Davol Stethoscope Tube. This modern tube will improve your present stethoscope. Latex for long life, heavy wall for durability and to exclude extraneous sounds, with length and weight just right to make it easy to carry and easy to use. One tube; twin channels. No obligation — want to try one? Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

TESTIMONIAL DINNER FOR 50 YEAR PRACTITIONERS

The community comprising Shelton, Derby, Ansonia and Seymour, occupies the unique position this year of having eight doctors who have practiced medicine fifty years or more.

A testimonial dinner is planned for these men, to be given January 15th, 1941 at the Hotel Clark, Derby. The names of the honored physicians are as follows:

Edward K. Parmelee, M.D.
Henry Steudel, M.D.
W. Sherman Randall, M.D.
Frank N. Loomis, M.D.
Royal W. Pinney, M.D.
Charles T. Baldwin, M.D.
Louis E. Cooper, M.D.

Tickets for the dinner will be available from January 1st to the 10th at Griffin Hospital, Derby. The price of the tickets will be \$2.00 and the number is limited to 250, and to doctors, nurses, hospital board members, and their families.

It is planned to make this an informal get-together and we hope that many friends of these physicians about the state will join with us in honoring these men in accordance with their long years of service.

Committee in Charge
Burton I. Tolles, M.D.
Thomas F. Plunkett, M.D.
Edward J. Finn, M.D.
W. Howard Treat, M.D.
Samuel B. Rentsch, M.D.

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MEDICAL — PHARMACEUTICAL COMMITTEE MEETS

The Conference Committee of the Connecticut Pharmaceutical Association and the Connecticut State Medical Society held its second meeting on November 26, 1940 at the Union League Club in New Haven. Present were Stanley B. Weld, M.D., Hartford, Chairman; John H. Foster, M.D., Waterbury; Walter I. Russell, M.D., New Haven; William M. Stahl, M.D., Danbury; John J. Dugan, New Haven, Secretary; Hugh P. Bierne, New Haven; I. Samuel Ragatsky, Hartford; Joseph Siliadi, Stamford. Absent, John C. White, M.D., New Britain.

The Secretary presented samples of a series of posters which could be used in drug store displays to dramatize the service of the physician and of the pharmacist to the public. The art of prescription writing was discussed with all its pitfalls, shortcomings and possibilities for improvement. Two problems were presented for solution, one, the prescribing by druggists for venereal disease, the other, the handing out of samples by physicians to their patients,

It is planned by this committee, if permitted a place on the programs, to present some of the more pressing problems common to physicians and pharmacists at the annual meeting of the State Medical Society in May and at the Clinical Congress in September.

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INDUSTRIALISTS AND DOCTORS

(Continued from Page 60)

Division, Niles-Bement-Pond Co., Hartford; Maurice B. Ullman, Secy., Strouse-Adler Co., New Haven; W. H. Pretto, Royal Typewriter Co., Hartford; Robert S. Carnell, Wallace Barnes Co., Bristol; Edward Bower, Sargent & Company, New Haven; C. H. Granger, President, Ingersoll-Waterbury Co., Waterbury; W. S. Cable, Employment Manager, Safety Car Heating & Lighting Co., Inc., New Haven; C. Roy Fugal, Personnel Manager, General Electric Co., Bridgeport; Thomas M. Webb, Personnel Manager, Bridgeport Brass Co., Bridgeport; Robert E. Carroll, Vice Pres., Arrow-Hart & Hegeman Electric Co., Hartford; James Lee, Frank H. Lee Co., Danbury; Donald McLachlan, H. McLachlan & Co., Inc., Danbury; E. O. Miller, Hartford-Empire Co., Hartford; Alan C. Curtiss, Scovill Manufacturing Co., Waterbury; and Miss F. Ruth Banford, A. C. Gilbert Co., New Haven.

Dr. Creighton Barker, Executive Secretary, expressed the desire of the Society to cooperate with the manufacturers to the utmost in carrying out the program. Other physicians present were Doctors Cole B. Gibson, Meriden; Norman E. Gissler, Middletown; Albert S. Gray, Hartford; Martin I. Hall, Bristol; Robert P. Knapp, Manchester; Bernard C. Peck, New Britain; Richard O'B. Shea, Bridgeport; Paul W. Vestal, New Haven; Donald B. Wells, Hartford; and Charles F. Yeager, Bridgeport.

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July 1, 1939 - June 30, 1940

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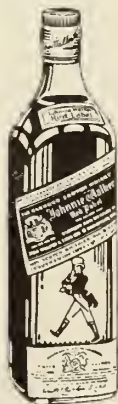
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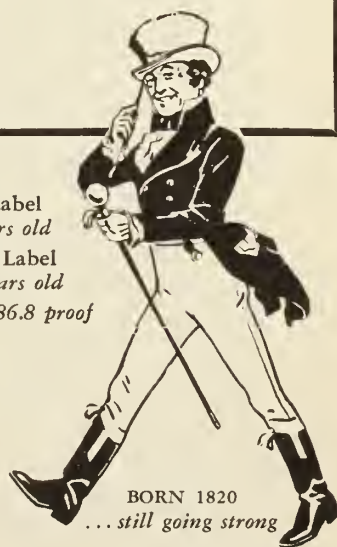
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SOCIETY CHANGES NAME

At the regular meeting of the Connecticut Society for Psychiatry held on Wednesday, December 11, 1940 at the Hartford Retreat, Hartford, Connecticut, it was voted to change the name of the Society to the Connecticut Society for Psychiatry and Neurology; and at the same time the membership qualifications were altered to make possible the admission of qualified neurologists.



INTERNATIONAL COLLEGE OF SURGEONS MEETS

The New England Activities Committee of the United States Chapter of the international College of Surgeons held its regular bi-monthly meeting in Hartford on September 19. It was voted to hold six Guild meetings during the year, one for each of the New England States. The first Guild meeting was held at the Massachusetts State Cancer Hospital in Westfield on October 10. The second Guild meeting will take place in New Haven on Thursday, January 9, 1941.

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Table of Contents



OFFICERS AND COMMITTEE CHAIRMEN:

Connecticut State Medical Society	4
Connecticut Hospital Association	4

ORIGINAL PAPERS:

Bellum and Cerebellum	C. Charles Burlingame, M.D., Hartford, Conn.	83
Anesthetic Control of Abdomen	E. A. Rovenstine, M.D., Ney York, N.Y.	88
Dr. Samuel Holden Parsons Lee: His Life and Times —		
	Alfred Labensky, M.D., New London, Conn.	92
Rupture of Uterus	Max L. Berlowe, M.D., New Haven, Conn.	97
Depressive Reactions in Middle Aged Men —		
	William B. Terhune, M. D., New Canaan, Conn.	104
State Aid to Blind in Connecticut	Eugene M. Blake, M.D , New Haven, Conn.	110

ABSTRACT:

Treatment of Coronary Disease	Herrman L. Blumgart, M.D., Boston, Mass.	102
-------------------------------	--	-----

CASE REPORT:

Synovial Sarcoma —		
	William Leichner, M.D., and Abraham Schaefer, M.D., Hartford, Conn.	113

STATE DEPARTMENT OF HEALTH:

Advances With Full-Time Health Leadership: Progress Reported in Middletown —		
	Franklin M. Foote, M.D., Hartford, Conn.	116

EDITORIALS:

America Needs a Credo		122
Some Observations on the Management of Acute Obstruction in the Small I testine		123
The Connecticut Plan For Hospital Care After Four Years		124
Organizing Your Town For Health		124
Midwinter Dinner of State Medical Association		125
Doctor Edgar A. Hines		126

FROM THE SECRETARY'S OFFICE

		127
--	--	-----

CONNECTICUT HOSPITAL ASSOCIATION:

Christmas Observance At Our Hospitals		130
Our Hospitals		132

THE DOCTOR'S OFFICE

		137
--	--	-----

OUR NEIGHBORS

		137
--	--	-----

MEDICAL PREPAREDNESS:

Miscellaneous		138
Planning For a Pandemic of Influenza	Millard Knowlton, M.D.	140

LEGISLATIVE SECTION

		152
--	--	-----

GENERAL PRACTITIONER'S FORUM

		153
--	--	-----

NEWS FROM COUNTY ASSOCIATIONS

		154
--	--	-----

NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE

		156
--	--	-----

SPECIAL NOTICES

		157
--	--	-----

OBITUARY:

Kate Campbell Mead	Jessie W. Fisher, M.D.	158
--------------------	------------------------	-----

QUARTO NOTES (Book Reviews)

		159
--	--	-----

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The Connecticut State Medical Journal

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No. 2

Bellum and Cerebellum

C. CHARLES BURLINGAME, M.D.,
Hartford, Conn.

The Author—M.D., 1908, General Medical College of Chicago. Assistant Physician, Westboro State Hospital (Mass.), 1908-1912. Assistant Superintendent and acting Superintendent, Fergus Falls State Hospital (Minn.) 1912-1915. Industrial Psychiatrist, Cheney Brothers, Manchester, Conn., 1915-1917, 1919-1921. Executive Vice-president, Presbyterian Hospital, N.Y.C., 1921-1928. Psychiatrist-in-chief, Neuropsychiatric Institute of the Hartford Retreat, 1931 to date. Fellow, American Psychiatric Association.

Believe me when I say that the title of my talk — Bellum and Cerebellum — is more than a mere play on words because when bellum comes, the thinking, most highly civilized portion of the brain seems to go to sleep. It is significant, I think, that the cerebellum in animals is much more important than it is in human beings, proportionately. Yet, even though war is not a reasonable thing, and even though it does drive before it all the highest cerebral functions, it does at the same time require the highest type of coordination within the country itself. Paradoxical, isn't it — that in the exercise of a purely brute function, the making of war, we are driven to greater coordination within the social group, with each unit in the group being called on to contribute its share toward the performance of complex functions. Thus we find the analogy with the cerebellum not too far-fetched.

We as psychiatrists, cannot hide in our ivory towers these days. Psychiatry as the art and science of understanding and treating human beings must certainly take cognizance of the world we are living in and what is happening to

us, and there are few things that have occurred in our lifetimes that transcend in psychiatric implications the events of the past few years and the unhappy events that are transpiring abroad and which, every day, seem to draw closer to us.

The mass upheavals in the lives of millions of people, not only physically but psychically, are bound to have their repercussions not only abroad but at home, too. Indeed, the acute psychiatric observer can already detect traces of these effects in individuals and in groups as well.

I think these things come well within the purview of psychiatric inquiry. I do not think that psychiatry must confine itself merely to metaphysical abstractions. If our profession has any real, widespread value to society then it is in the marketplace, in the arena, in the highways and byways where men are rubbing shoulders in the sweat and competition of life.

As psychiatrists we must ask, looking beyond the surface of events and digging deep into causes, the whys and the wherefores of events when "judgment thou has fled to brutish beasts and men have lost their reason."

There isn't a reasonable man even faintly conversant with everyday affairs who would discount for a moment the tremendous importance of the psychological components in the preparation for warfare, and in the carrying out of successful warfare. In recent years we have seen these psychological components played to their utmost by the German dictator who, like a master musician, has played

on the emotional strings of whole nations, bringing about at will mass depressions, mass anxieties — yes, and mass hysterias.

Yet, in spite of the widespread awareness of the value of psychological forces today, there are few if any of the leaders of people during these past few years who have apparently taken the trouble to find out what has been behind the terrific upsurge of Germany, the terrible outcropping of hatred and vengeance, the wild almost psychotic rantings of the German leader, and the truculence of the German people themselves.

It is no isolated example in history; it has repeated itself time and time again. There have been mad rulers before this — kings and emperors who have ravished and killed in sadistic orgies of blood lettings. There have been mass psychoses in which whole peoples have for periods of time been under the spell of an illusion. One has but to think of the dancing manias of the middle ages, and more recently in our American history of our witchcraft killings, to realize how easily possible it is for whole peoples to become blinded to realities, — to become lost to reason.

It should have been apparent to the statesmen of Europe long ago that Herr Hitler was not a phenomenon — he was not; he was a logical outgrowth of the sickness of the German people. Times make the man. Herr Hitler has not made present-day Germany — he becomes the spearhead only because he articulates the feelings and the emotions of a whole race of people — because he typifies them in his frustration, his vengefulness and his hysterical will to power, which in his person is only the microscopic emotional constellation that is repeated and was repeated by the German people themselves.

Strange indeed now, to look back to Munich and to the days before Munich, that there should have been so little insight into the character of this man. Strange that British and French statesmen could not have been aware of the fact that they were dealing with an emotional deviate. Hitler has been called a schizophrenic, a hysteric, a homosexual. Pinning a label on him doesn't explain him, but whether he be all of these things or not — and he is unquestionably a deviation from the normal — it is obvious from his speeches and

from his writings, particularly *Mein Kampf*, that he is not a man who could be expected to respond to situations in the same way that a normal man would respond. That would be impossible for him to do for the world he lives in — his private world — is not the world of normal men, and his responses are not normal.

The grave and tragic error, then, was to assume that he could be dealt with as a normal man, and in this respect the statesmen of the world were guilty of tragic blindness. It would not have taken a very expert psychiatrist years ago to have informed Mr. Chamberlain that a sick man had come to power in Germany — and that no matter his brilliance, no matter the sway he held over the German people, the plain incontrovertible fact was that he could not be expected to function in a normal way, nor could he be expected to react in a normal way.

Now, as I say, the mass sickness of nations is not a new phenomenon in history. Nations are not artificial entities; they are composed of the living stuff of human beings, and when all these human beings are exposed to certain conditions over a period of time, there is a mass conditioning that makes that nation as some gargantuan creature, thinking with one mind and being stirred by one set of emotions. Hitler merely speaks for that mass. He has been made by the times he lived in, for in another day, under happier circumstances, he would at least have been an outpatient at some psychiatric hospital by now.

When these soft spots appear in the thinking of a nation, if the nation is fortunate, there appears one who has escaped the ravages of the common virus, and who by sheer strength brings the people back to reason and rids them of the burden of the delusion under which they are laboring. It is almost as though the people were suddenly conscious, as a psychotic patient is conscious for one brief moment, that they are not right and in that moment of lucidity they place their fate in the hands of a leader. England, which had been growing faithless and indifferent, choked for centuries by an aristocracy and suffering for years a social inequality among her people, seemed to have one of those moments of lucidity in her choice of Churchill, a man who had seen the dreadful virus of smugness and self-satis-

faction sweeping over his country like an opiate, and who had tried for several years to awaken them to the danger.

And so, from the psychiatric viewpoint, if we view the present crisis we find the same forces at work on a national and international scale that we find in the individual workings of the human mind. We find smugness, laziness, indifference and cynicism in mal-functioning human beings, and we find it in nations. We find hysteria, paranoia, hatefulness and suspicion in individuals, — and we find these same traits in nations.

You and I who have worked with individual patients know that the reintegration of the patient toward a definite goal gives him strength far beyond that of the casual straggler who takes each day as it comes. What is true of the individual is true of the nation. Hitler has a plan and he was first to conceive of the application of psychological principles in his preparation for war. He conceived of the application of those principles not only at home, but abroad. At home, by the power of suggestion, he supplied certain ideas to his people so that they thought with practically a single mind. Abroad he sowed the seeds of weakness; he appealed to the greed, the avarice, the ambition of individual men. He spread the doctrine of defeatism, he capitalized on the cynicism and the moral weakness of whole nations who had forgotten that there is strength in a credo. He went beyond the realm of the average psychologist in that he analyzed the psychological weaknesses not only of individuals but of whole peoples. And, with the sole exception of England, which he has manifestly misjudged — and of the United States, where an even greater surprise may await him — he has done a singularly fine job of analytic interpretation and a superlative job of applied psychology.

Because Hitler is a hysteric is no reason for believing that his thinking is not lucid. His ends may be cockeyed, and his drives may have their wellspring in a morass of emotional mal-adjustment, but he has given the rest of the world something to think about in the way of applying knowledge.

And even now, there seems to be little or no effort on the part of any other nation to play him at his own game — for Hitler has a psy-

chology that is particularly vulnerable, and the German people have a psychology that is particularly vulnerable.

In contrast to Churchill who is obviously an adult, well matured individual in contact with reality and with a sense of world values, Mr. Hitler presents an interesting but comparatively simple problem in psychopathology, and one that should be fairly familiar to those of you who have worked in child guidance clinics. It is the character pattern of the bully. The bully, as you all know both from your professional experience and from your personal experiences in childhood and adolescence, has an inadequate ego — he suffers from emotional retardation. Bullying is a desperate attempt at ego satisfaction through the defeat of younger or smaller opponents. It naturally implies the ability to roar "foul" at your opponent while at the moment you are gouging out his eye. Above all, it implies bluster and bluff, lack of sportsmanship and an utter disregard of the rules of the game. Men who are intrinsically weak and inadequate sometimes become very successful bullies, and they may go for years and years carefully choosing their opponents, making certain that their ego is not endangered by an encounter with an opponent of nearly equal size and ability. The bully must have the cards always stacked in his favor; he must have all the odds on his side. You and I know that once the odds are nearly even, or if they favor an opponent, then the bully is licked even before a blow is struck.

It seems to me to be particularly important today to remember that fact in our appraisal of the world scene, and for us to remember that bluff and bluster, vengefulness and cruelty are the marks of weakness, not strength — for what is true of the pathetic patient you observe in your clinic is equally true of the men who through force of circumstance are now occupying the world stage.

As psychiatrists, and as citizens of the United States — and I think the latter is by far the more important — you and I, and a lot of other physicians, are going to be drafted for public service in the next few weeks and months. We are going to have to drop our role as advocate for the patient and assume a judicial role. We are going to take our places as units in the great machinery that is being set up, and the question

is — how are we going to function best to serve the nation most adequately?

First of all, we need a change in our point of view — most of us. We've got to have a new kind of thinking, a kind that leads us to understand that our province extends beyond the asylum, — that the facts and the observations we have accumulated as a part of our experience in dealing with the abnormal can be, and should be, used in our everyday life and in our contribution to the community. We've got to start thinking in terms of communities, and cities, and states — in terms of the country as a whole, and not in terms of the individual patient. That's one thing.

The draft of the last war gave tremendous impetus for many social gains, for the draft is a national assay of the most valuable thing we've got — young, vigorous manpower. The last draft showed with clarity some of the weaknesses of our social structure — it was the spectroscope that penetrated through the stuff that makes up our country, and it showed defects which, by the showing, have now been largely counteracted by subsequent reforms. The selective service lifts the cover off things; it brings into sharp focus the evils and the lackings of the community, the lack of proper medical or dental care, the malnutrition and the general neglect that over a period of time has its indelible stamp on the men who come to be examined.

Let's go into this inventory with open eyes, not only for the problem at hand but for the future. Let's remember that some of these boys who are coming to us for examination are boys who have been through the vicissitudes of the economic life of the past ten years. Some of them will bear the scars of those years on their personalities, and in these instances let us exercise the rule of reason.

For some reason a lot of people seem to have the impression that a year's service for one's country in the army is an unmitigated evil. In a great many instances that I can think of — even beyond the natural duty one owes to one's country — I can see where it will be a blessing.

A great many of these boys will come with psychic scars and your first inclination will be

to dub them "unstable." Don't do that, I beg of you. By turning them down, you might be turning the key in the lock of the door that will lead them to health. Some of these so called "unstable" individuals will find a new life in the army where, under intelligent discipline, with the security and the regular direction they will receive, they will become useful citizens.

Of course, I am not urging that you admit a lot of psychopaths into the army — not that. But there is a vast difference between the constitutional inferior, the psychopath who has a basic, almost innate pathology, and the youngster who has been battered and buffeted around — economically, socially and every other way — so that the psychic wounds are raw. The army, I say, will be a Godsend to a lot of boys like that, just as the CCC was to another army of youngsters who were living on the ragged edge and to whom the CCC meant a new way of life and a chance to grow to healthy manhood.

And another thing, as the rising tide of emotion begins to swirl stronger and stronger, with our knowledge of human emotions and the well-springs of human conduct, we should all of us be bastions of reason and common sense. This may sound like abstract advice to those who may be too young to remember the last War, but I'm sure old timers like myself will remember only too well how suddenly the false becomes true and the truth is buried beneath a sea of emotion, hatred and vengefulness. It is in times like that when all the paranoid trends come to the surface — all the unresolved mental conflicts and hysterias appear, all the spitefulness of inadequate personalities comes rushing to the fore — for the cerebrum has been blackjacked and the primitive brain has taken over — the primitive brain that supplies the drive, the primitive brain that coordinates activities, but the primitive brain of the nation, nevertheless, that is lacking in the ability to form abstract principles, and which does not represent man at his best.

America will grow strong by not entirely abandoning the functions of the cerebrum not by persecutions and terrorism. Putting the little butcher out of business because he has a German name will never make a nation strong;

it makes us weak, just as Germany will grow progressively weaker as her hatred grows stronger and then suddenly transforms itself into despair and depression, — for when I speak of strength I am referring to *esprit de corps*. England will grow stronger because England has at last got her feet on the ground of reality, because England is following a man who has not given himself over to the workings of his primitive brain exclusively, but a man who even at the darkest moments has not given himself over to the luxury of wild hatreds, threats of vengeance — only to thoughts of protecting his Island Home. *Esprit de corps* doesn't take the place of planes, of course, but it does make one plane do the work of three.

We can do our part, each in his own community, to combat this kind of petty meanness that lies in persecution by speaking out against those things and trying to foster within the sphere of our own influence an appreciation of the real psychology of strength — as compared to the undisciplined weakness of hatred and persecution.

And there is another thing, which at first blush may sound strange to you. I believe that a great deal of the cynicism, the lack of virile strength, the loss of some of our own dynamic powers as a people, have come about directly as a result of some of the things which some of us in psychiatry have ourselves talked and practiced. Some of these psychological concepts are the outgrowth of a tired intellectualism, decadency if you will. They break man down into little bits, analyzing, scrutinizing and weighing each phase of his personality, forgetting that the sum of the parts does not make the whole, any more than the action of water can be explained by the sum of oxygen and hydrogen. Man is something above and beyond the mere addition of his traits, yet these teachings would leave us no

hope and would destroy man's estimate of his own nobility. This doctrine of looking back into man's beginnings, to the ignoble origins of all his activities, instead of looking forward to man's future — this doctrine of the intrinsic brutality of human nature is a doctrine of cynicism and despair.

We have been guilty, I think, of helping man to be suspicious of his own motives, for how can one be courageous and then be dubbed a mere exhibitionists? How can one be meticulously honest and then be told that it is merely overcompensation for some hidden vice? How can one ever give expression to any decency of thought, word, or deed when it is translated into terms of indecency? Such a philosophical concept of regarding man analytically rather than considering him as a functioning organism with some pretty high motives sometimes and capable of some pretty lofty reaches in his thinking, is a brittle, cynical philosophy.

America needs no doctrine of cynicism now; it needs a credo. As a people we need a belief in ourselves, not only as citizens of this country but as human beings with potentialities for strength and purposeful achievement far beyond anything we have yet known. Within our powers we must help in preaching that doctrine. As Archibald MacLeish said recently, the writers of this generation have led young America into ways of cynicism as an outgrowth of their own disillusionment. We in psychiatry have done our part, too, for in the bewilderment of our own discoveries in the study of the mind of man, we have played a part in fostering the belief in man's inherently carnal, brutish nature. This is a belief that never offered hope or encouragement to anyone anywhere; it is a doctrine of despair. For that tired intellectualism let us preach a dynamic doctrine of man's dignity.

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(SEE PAGE 2.)

The Anesthetic Control of the Abdomen*†

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Every anesthetist has had the perplexing experience of a surgeon demanding "more relaxation" at a time when the degree of narcosis had already paralyzed the intercostal musculature and practically eliminated diaphragmatic activity. Not infrequently such instances produce the worst possible situation for the patient, namely, an aggravated surgeon roughly manipulating the abdominal contents in a vain effort to secure exposure and the bewildered anesthetist striving with seemingly little success to increase the tension of anesthetic agent in the patient's tissues. The frequency of this condition in the experience of some surgeons has stimulated their preference for spinal anesthesia. Especially is this true of those surgeons who require the maximum relaxation for abdominal manipulations and those who are not particularly gentle in handling tissues. Moreover, not a few anesthetists welcome subarachnoid block and the assurance that at least the gastro-intestinal tract will be in a contracted state and occupy a minimum of space in the abdominal cavity. No anesthetist lacks confidence in his ability to relax the recti and other skeletal muscles with inhalation anesthesia, but many have failed often in securing control over abdominal contents. When patients are encountered where a failure to obtain a controlled abdomen is too obvious the friendly surgeon may excuse the anesthetist by agreeing "that the patient took a bad anes-

thetic." Patients take what is given them and if is "bad" it was probably given incorrectly. The anesthetist may excuse himself by classifying such patients as having more than the usual "resistance" to the effects of anesthesia.

The argument is often advanced and it seems justified, that when the surgeon is handicapped by intestines obstructing the operative field or by inadequate relaxation of abdominal muscles during inhalation anesthesia, most harm is done the patient. The operative procedure may not be satisfactorily completed, the operating time may be greatly prolonged, and more trauma from retraction, handling and exposing tissues is necessary. Whereas, with spinal anesthesia, convenience and greater assurance of the dexterous completion of the operation outweigh the circulatory disturbances that may be encountered with its use. It is, of course, definitely understood that the patient is in the operating room for surgical therapy and that anesthesia is merely an accessory. If for any reason the operation is not properly completed the entire therapeutic procedure is not only futile but a serious handicap has been placed in the patient's way to recovery. If improperly administered inhalation anesthesia prohibits the completion of an operation, or, if the difficulties experienced by the surgeon make it impossible to complete his adjustments without seriously jeopardizing the patient, some other method for pain relief and relaxation should be chosen. However, to select any one anesthetic procedure as routine for any specific operation is an admission that the anesthetist lacks the ability to perfect his technics so that they may be individualized for the patient rather than for the operation. It would simplify anesthesia tremendously if one could be assured that every patient who requires a thyroidectomy, a thoracoplasty, a gastric resection, or any other

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†A condensed form of the paper read before the combined meeting of the Section on Anesthesia, Connecticut State Medical Society, and the American Society of Anesthetists during the 16th Clinical Congress, New Haven, Sept. 17-19, 1940. A complete list of references is included for the benefit of those specializing in the particular field under discussion.

specific operation, has an identical physical status and the same reaction to effects produced by the anesthetic drug and technic. Then the anesthetist would be justified in selecting the anesthetic procedure for the operation. That not being the case, the anesthetist is obligated to rigidly individualize his procedure for the patient. Those obtaining satisfactory results after a specific operation with spinal anesthesia will have patients for whom another method should be used. Anesthetists whose experience indicates a preference for inhalation anesthesia will encounter patients with definite contra-indications for such a procedure.

Improved Technics for Controlling the Abdomen

One fact is emphasized in the question of the anesthetic control of the abdomen and its contents. That is the obligation anesthetists have in perfecting technics so that with the one best indicated for a particular patient satisfactory operating conditions will be obtained. That such efforts and some success in this direction are being made can be assessed from recent reports in the anesthesia literature. Noteworthy is the recent description by Guedel of a technic for cyclopropane anesthesia¹. Guedel insists, and surgeons for whom he has administered such anesthesia agree, that the operating conditions are "more desirable than with the best spinal anesthesia in all patients." Although this method or some modified form of it has been used by a number of anesthetists for a considerable time, none, except possibly Guedel's associates and followers, are sufficiently familiar with it to propose a definite evaluation or analysis of results. The method utilizes the apneic technic or complete control of the respirations by the anesthetist. It is recommended that for convenience and safety an endotracheal airway be used. Premedication includes a moderate amount of morphine and scopolamine. Anesthesia is induced with an intravenous barbiturate and the endotracheal airway put in place. Then a 50% mixture of cyclopropane with oxygen is added by controlled respirations. Deeper anesthesia is obtained by changing to a 75% mixture of cyclopropane. The anesthetist carries on controlled respirations throughout the procedure and adds more 75% cyclopropane as needed

for relaxation. The patient is not allowed spontaneous respirations until the abdomen is closed. The value of the intravenous barbiturate and the rapid addition of much cyclopropane lies in their protection against cardiac arrhythmias. Guedel believes that there exists an "arrhythmic area" or a degree of cyclopropane narcosis above and below which arrhythmias do not occur and he wants to pass through this area as quickly as possible.

Guedel has employed this method for 8 years. His enthusiasm stimulated our interest 4 years ago. Our present application of the apneic technic differs slightly. The method used here takes advantage of the removal of the anoxic respiratory stimulus to produce apnea and, therefore, may be applied with less premedication and a smaller amount of cyclopropane.

Whether or not the technic advocated by Guedel to control the abdomen and its contents, or some modification of it, will gain wide acceptance, can only be answered when more anesthetists have mastered the method and evaluated the results. Surely the flaccid abdomen secured with it surpasses any safe degree of relaxation that can be obtained with ether. Ether when given to produce a depth of anesthesia where relaxation is comparable to that described by Guedel will destroy muscle tone, interfere with vaso-constriction and rapidly lead to shock.

Other technics that have been utilized in attempts to control the abdomen during inhalation anesthesia have made use of a combined nerve block or infiltration of local anesthetic drug. These methods have considerable promise and their application has not received the careful study they deserve. It seems altogether likely that technics for regional nerve blocks could be developed to provide adequate relaxation, pain relief and eliminate traumatic reflexes. Combined with light inhalation anesthesia with the gases, an additional advantage is secured by removing the elements of psychic trauma and asphyxia.

Abdomen

Efforts to aid the anesthetic control of the abdominal contents have not been limited to new technics. The use of drugs whose pharmacological effects prevent unfavorable con-

ditions are being employed. One example is the use of novatropine preoperatively to eliminate motility and tonus of the gastro-intestinal tract during anesthesia. The pharmacological action of this drug is similar to atropine. It is somewhat less potent than atropine but much less toxic. Large doses may be given without fear of the untoward reactions that would follow comparable doses of atropine. The drug is marketed in ampoules containing an aqueous solution (1 cc.) with 5 mgm. novatropine.

Studies have been completed on the effects of novatropine on various portions of the gastro-intestinal tract of unanesthetized human subjects⁵. There was complete cessation of motility with as little as 2.5 mgm. of novatropine. In addition, a marked reduction in tone was observed.

Another series of observations on the efficacy of novatropine were completed during anesthesia for operations upon the abdominal gastro-intestinal tract. These studies revealed briefly that novatropine eliminates or markedly reduces the tone and motility of the gastro-intestinal tract and thus may be used with advantage for this purpose during abdominal surgery⁵.

Traction Reflexes During Abdominal Surgery

The anesthetist will not have discharged his obligation in the control of the abdomen during surgery with the proper choice of anesthetic agent, premedication and technic until he has also minimized the physiological disturbances that may result from the surgeon's manipulations. One group of such disturbances is commonly referred to as traction reflexes. These are frequently encountered and are responsible for some of the most significant cardio-vascular and respiratory changes with which the surgeon and anesthetist have to contend.

Perhaps the most frequent mechanical or traction reflexes are those arising from manipulation of the abdominal viscera. They may occur upon handling viscera in either the lower or upper abdominal regions. As a rule, the more profound changes occur when the viscus is nearer to the diaphragm. The circulatory disturbances in man are commonly characterized by a gradual or an abrupt fall in blood

pressure with a significant decrease in pulse pressure. The systolic falls proportionately more than the diastolic with no significant change in the heart rate and suggests a sudden change in cardiac output. The importance of such changes lies not only in the degree and duration of circulatory depression but particularly the potential or active cardiovascular disability of the patient. Decrease in blood pressure and particularly pulse pressure, if permitted for any length of time, especially in individuals with a disabled cardiovascular system, will usually result in circulatory collapse or shock.

Control of Traction Reflexes

In the light of present knowledge it does not appear probable that the anesthetist can regularly determine by preanesthetic examination the reflex effects that may be encountered after manipulations within the abdomen are begun. If such prognosis could be made accurate, prophylaxis for untoward effects could be approached scientifically by the choice of premedication and anesthetic agent. One may only anticipate effects that follow stimulation of sympathetic fibres when drugs such as ether or chloroform are employed and, more particularly, if they are used in atropinized individuals. Effects from parasympathetic stimulation may be expected when cyclopropane is employed. The use of adrenalin with cyclopropane would enhance the possibility of such efforts, but with atropine they would be decreased.

Any discussion of ways and means to prevent "traction reflexes" must necessarily include the surgeon's role. The entire responsibility for untoward reactions produced mechanically belongs to the surgeon. The anesthetist can do little more than advise with observations upon the status of the circulation. The reflexes that are produced by traction and by trauma will be minimized if the tissues are handled gently and with dexterity; they will be magnified when the viscera are roughly manipulated, when packs are injudiciously or unnecessarily used, when traction is severe or indiscriminate, and when positions such as extreme inversion or with the feet and head both lowered are employed. Unfavorable reflex reactions are more frequently observed when

high gall bladder lifts are utilized than when the patient is on a level table. Beginning the operative procedure before anesthesia is properly adjusted invites discouraging results, and persisting while the anesthetist attempts to make adjustments practically insures unsatisfactory if not dangerous sequela.

The actual treatment of the reactions arising from "traction reflexes" deserves the consideration and cooperation of both anesthetist and surgeon. When muscle rigidity interferes with convenient operating it seems apparent that the degree of narcosis could be increased until the muscles were flaccid. This is not always easy to accomplish. There is a difference in opinion among experienced observers concerning the depth of anesthesia needed to abolish the reflexes, but there is agreement that it differs widely in individuals. Some patients will require a dangerous overdose of the anesthetic agent to abolish reflex activity and accomplish adequate relaxation. It may not always be the part of wisdom to "push the anesthetic" until convenience for the surgeon is obtained. If the concentration of the anesthetic agent in the blood necessary to control the abdomen causes circulatory depression, the safety of the patient is sacrificed to accommodate the surgeon. If the anesthetist chooses to increase the depth of anesthesia well beyond that ordinarily required for the operation in progress, an endotracheal airway is indicated or the apneic technic is to be instituted, the surgeon should permit him to complete the effort without hindrance. Manipulations that may be responsible for the patient's status should be suspended. Packs and retractors should be removed or readjusted and the position of the patient may need to be changed. If the mechanism responsible for the unsatisfactory conditions is associated with drug effects, a change of agent or the use of other drugs to antagonize the undesirable reactions may be of value.

Summary

The anesthetic control of the abdomen implies relaxed skeletal muscles, a flaccid peritoneum and quiet unobstructing intestines. These requirements are not always easy to satisfy with inhalation anesthesia. Recent de-

velopments in technics and drug therapy have aided the anesthetist in his efforts to control the abdomen and its contents. Guedel has introduced an apneic technic with cyclopropane. A modification of this method is described. Combined regional and inhalation methods are being developed and improved.

Drugs effecting the tone and motility of the gastro-intestinal tract are being used during anesthesia. Novatropine to reduce tone and pitressin to constrict the intestines, examples of such therapy, may be used to advantage during abdominal operations for certain patients

Further control of the abdomen is obtained by eliminating respiratory and circulatory changes that may often follow surgical manipulations. Such reactions, known as "traction reflexes" are described and their prophylaxis and treatment discussed.

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Dr. Samuel Holden Parsons Lee: His Life and Times

ALFRED LABENSKY, M.D.
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The Sesquicentennial of the Connecticut State Medical Society will be celebrated at Middletown in 1942. In anticipation of that event the *Journal* is publishing a series of historical papers on different phases of medical history in the eight counties of Connecticut. The following from the pen of Doctor Labensky is the fourth in this series. (*The Editor.*)

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Prologue

The clock has been turned back a century and a half. It is August 22, 1798. The long stifling day comes to a close and the setting sun tips the parched brown ramparts of Ft. Griswold, but the setting of the sun brings no relief from the heat. No vagrant breeze stirs the rigging of the ships moored against the wharves facing Beach St. The ships move a little with the tide, groaning as their sides rub against the piles. From the Groton shore the lowing of cattle comes dully through the dead air. The long summer twilight fades into black sultry darkness.

Aboard the ships the sailors sluice themselves with buckets of water and change their clothes to go ashore. They make for the inns to slake their thirst with ale; it is too hot even to think of tumbling a wench. Slowly they trudge along the water-front and leave behind them the mingled odors of cattle, molasses and spices. At the market building on the north side of the Parade they separate. Some turn to the right to the tavern at the corner of Main St. under the buttonwood tree. The others cross the dusty parade ground towards the dimly lighted window where Col. Jedidiah Huntington is trying to catch up with the paper work of his busy customs office. A little farther to the south on the opposite side of Bank St. is their goal, Capt. Lije Bingham's

coffee-house where they can joke with pretty Polly Bingham the captain's twenty-year old daughter while they drink their ale.

As they pass along the east side of the street a foul stench causes them to hurry and they curse the thriftiness of the merchant who has sought to salvage some spoiling dry codfish by spreading it on racks in front of his shop. Just beyond is their destination and breathing freely again they enter Captain Lije's tap-room.

No one is there. Even Captain Lije is missing from his customary place behind the bar. They seat themselves at the tables, too languid to call for service. After a little while the door at the back of the room opens and Polly enters. She smiles absently at their jests and appears tired and worried. Her father (she says) has been taken sick with fever and vomiting and in spite of all that she and her mother can do he is much worse and her brother Sluman has gone to fetch Dr. Lee.

As she speaks Dr. Lee enters, a fine tall vigorous man. The heat has not diminished his vitality and as he strides across the tap-room the candles flicker in their sconces at his brisk passage. Polly excuses herself and follows him.

He soon reappears. To the sailors' friendly inquiry he says that the captain is indeed very ill with the bilious fever. They know what that is. When they left Martinico people were dying of it there and they had lost two ship-mates with it on the voyage north. It is still raging in Boston.

They leave hastily and go out into the black night. A damp mist which chills without cooling has drifted in from the river. As they

recross the Parade the mosquitoes drone and bite viciously. A wan moon stencils the ships' masts where they rise above the mist. Back aboard their vessels they spread their pallets on the decks and sleep fitfully.

In a few days Captain Elijah Bingham, his wife and his son Sluman and his daughter Polly are dead of the yellow fever.

* * * *

"At a meeting of the New London County Convention, at the city of New London, on the 4th Tuesday of Sept. 1793 —

On application of Doct^r Samuel H. Lee, to be admitted a member of this society Doct^r Lee produced letters testifying his having acquired sufficient knowledge to practise Physick and Surgery, from Doct^r Bailey of New York and sundry other gentlemen

Voted That Doctor Samuel H. Lee be admitted a member of this convention."

Thus begins the medical career of Dr. Samuel Holden Parsons Lee. He was born in Lyme August 5, 1772; the son of Capt. Ezra Lee who navigated the first submarine, David Bushnell's Turtle, during the Revolution. His mother was Deborah Mather also of Lyme. In March 1794 he married Elizabeth Sullivan, daughter of the purser of the British warship Cygnet, a frequent visitor to New London harbor in the years after the Revolution.

The young couple settled in New London newly rebuilt after Arnold had burnt the town in 1781. There he opened an office and store on State St. — for he was not only physician and surgeon but druggist also and not unlike our modern druggists he sold paints, varnishes, seeds and rum.

The New London of 1793 was pre-eminently a seafaring town. To the wharves down the dusty country roads came droves of mules and cattle to be loaded aboard ships for the West Indies, to be traded there for molasses and rum which filled the warehouses along Beach (Water) St. From Europe came broadcloths, crockery, spices and steel ware to be sold in the shops along the Parade. The importance of this traffic can be realized when one finds sailing from New London at this time in the European and West Indian trade 3 ships, 84 brigantines, 38 schooners and 90 sloops.

As in all seafaring towns life was enlivened by the antics of sailors enjoying liberty after

a long cruise, said liberty usually ending in the town gaol conveniently situated at the wharf-side at the foot of the Parade. If their comrades were in the right mood it was the work of but a few playful minutes to break in the door of the gaol and release them.

Miss Caulkins, in her history of the town, says regretfully; — "Ignorance, discord, profanity and rowdyism were lamentably prevalent." She goes on to say that before church services there was talking and laughing about the church. Directly after service boys and girls were calling to one another, and worst of all, boys and girls pitched quoits and played ball on Sunday afternoon.

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Dr. Samuel Holden Parsons Lee:

His Life and Times

ALFRED LABENSKY, M.D.
New London, Conn.

The Sesquicentennial of the Connecticut State Medical Society will be celebrated at Middletown in 1942. In anticipation of that event the *Journal* is publishing a series of historical papers on different phases of medical history in the eight counties of Connecticut. The following from the pen of Doctor Labensky is the fourth in this series. (*The Editor.*)

The Author—Laboratory and x-ray technician, Lawrence Hospital, New London, 1912-1915. Middlebury College, 1915-1916. Yale Sheffield Scientific School, 1916-1917. M.D., 1921, Yale. Medical staff, 1923 to date, chief of staff, chief of medical service, and director of x-ray, Lawrence and Memorial Associated Hospitals, New London.

Prologue

The clock has been turned back a century and a half. It is August 22, 1798. The long stifling day comes to a close and the setting sun tips the parched brown ramparts of Ft. Griswold, but the setting of the sun brings no relief from the heat. No vagrant breeze stirs the rigging of the ships moored against the wharves facing Beach St. The ships move a little with the tide, groaning as their sides rub against the piles. From the Groton shore the lowing of cattle comes dully through the dead air. The long summer twilight fades into black sultry darkness.

Aboard the ships the sailors sluice themselves with buckets of water and change their clothes to go ashore. They make for the inns to slake their thirst with ale; it is too hot even to think of tumbling a wench. Slowly they trudge along the water-front and leave behind them the mingled odors of cattle, molasses and spices. At the market building on the north side of the Parade they separate. Some turn to the right to the tavern at the corner of Main St. under the buttonwood tree. The others cross the dusty parade ground towards the dimly lighted window where Col. Jedidiah Huntington is trying to catch up with the paper work of his busy customs office. A little farther to the south on the opposite side of Bank St. is their goal, Capt. Lije Bingham's

coffee-house where they can joke with pretty Polly Bingham the captain's twenty-year old daughter while they drink their ale.

As they pass along the east side of the street a foul stench causes them to hurry and they curse the thriftiness of the merchant who has sought to salvage some spoiling dry codfish by spreading it on racks in front of his shop. Just beyond is their destination and breathing freely again they enter Captain Lije's tap-room.

No one is there. Even Captain Lije is missing from his customary place behind the bar. They seat themselves at the tables, too languid to call for service. After a little while the door at the back of the room opens and Polly enters. She smiles absently at their jests and appears tired and worried. Her father (she says) has been taken sick with fever and vomiting and in spite of all that she and her mother can do he is much worse and her brother Sluman has gone to fetch Dr. Lee.

As she speaks Dr. Lee enters, a fine tall vigorous man. The heat has not diminished his vitality and as he strides across the tap-room the candles flicker in their sconces at his brisk passage. Polly excuses herself and follows him.

He soon reappears. To the sailors' friendly inquiry he says that the captain is indeed very ill with the bilious fever. They know what that is. When they left Martinico people were dying of it there and they had lost two ship-mates with it on the voyage north. It is still raging in Boston.

They leave hastily and go out into the black night. A damp mist which chills without cooling has drifted in from the river. As they

recross the Parade the mosquitoes drone and bite viciously. A wan moon stencils the ships' masts where they rise above the mist. Back aboard their vessels they spread their pallets on the decks and sleep fitfully.

In a few days Captain Elijah Bingham, his wife and his son Sluman and his daughter Polly are dead of the yellow fever.

* * * *

"At a meeting of the New London County Convention, at the city of New London, on the 4th Tuesday of Sept. 1793 —

On application of Doct^r Samuel H. Lee, to be admitted a member of this society Doct^r Lee produced letters testifying his having acquired sufficient knowledge to practise Physick and Surgery, from Doct^r Bailey of New York and sundry other gentlemen

Voted That Doctor Samuel H. Lee be admitted a member of this convention."

Thus begins the medical career of Dr. Samuel Holden Parsons Lee. He was born in Lyme August 5, 1772; the son of Capt. Ezra Lee who navigated the first submarine, David Bushnell's Turtle, during the Revolution. His mother was Deborah Mather also of Lyme. In March 1794 he married Elizabeth Sullivan, daughter of the purser of the British warship Cygnet, a frequent visitor to New London harbor in the years after the Revolution.

The young couple settled in New London newly rebuilt after Arnold had burnt the town in 1781. There he opened an office and store on State St. — for he was not only physician and surgeon but druggist also and not unlike our modern druggists he sold paints, varnishes, seeds and rum.

The New London of 1793 was pre-eminently a seafaring town. To the wharves down the dusty country roads came droves of mules and cattle to be loaded aboard ships for the West Indies, to be traded there for molasses and rum which filled the warehouses along Beach (Water) St. From Europe came broadcloths, crockery, spices and steel ware to be sold in the shops along the Parade. The importance of this traffic can be realized when one finds sailing from New London at this time in the European and West Indian trade 3 ships, 84 brigantines, 38 schooners and 90 sloops.

As in all seafaring towns life was enlivened by the antics of sailors enjoying liberty after

a long cruise, said liberty usually ending in the town gaol conveniently situated at the wharf-side at the foot of the Parade. If their comrades were in the right mood it was the work of but a few playful minutes to break in the door of the gaol and release them.

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uncommon size made life doubly miserable.

Then, on Wednesday, August 22, Elijah Bingham was taken ill. He rapidly grew worse and on Sunday the 26th he died of yellow fever. He was buried the same day and his funeral was attended by a large number of citizens as he had been a popular man and a prominent Mason. Soon his wife, son and daughter joined him under the earth at the burial ground at the corner of Broad and Hempstead St. Within a week twenty-five people died of the disease.

The citizens became panic-stricken. They fled from the town in large numbers, some even abandoning sick parents or children. Doctors joined in the exodus. Of seven who practised in the city (which then including Waterford had a population of about three thousand) only three remained, Dr. Rawson, Dr. Thos. Coit and Dr. S. H. P. Lee. Even the city officials fled and a Health Committee consisting of John Woodward, John Ingraham, James Baxter and Ebenezer Holt, Jr. was appointed. These brave men took over the task of supplying food, clothing and accommodations to the sick and burying the dead. The Court House was taken over as a hospital. Donations for the care of the sick were soon pouring in.

Soon many more fell ill and deaths occurred so fast that burial services became more and more perfunctory. Then both Dr. Rawson and Dr. Coit fell ill and the care of all the sick fell on Dr. S. H. P. Lee. It was well that he was young and rugged — he was 26 at the time — for he had to make from 20 to 50 calls a day. For six weeks he did not have his clothes off. His colored slave who drove him about is said to have shook him awake at each stop.

In his treatment he followed the precepts of the illustrious Dr. Benjamin Rush and bled, purged and salivated his patients. He also used his celebrated New London Bilious Pills both for the prevention and for the treatment of the disease. He says of them in one of his advertisements in the Connecticut Gazette: — "Those who have taken his pills every 4 to 6 days and have lived temperately have escaped the disease." At another time he says: — "A severe attack was carried off by a very powerful dose of Lee's New London Bilious Pills."

He himself contracted the disease in Sep-

tember. Although it may have been possible for him to take his pills, it certainly was not possible for him at the time to lead a temperate life, so there is some excuse for his contracting the disease. His kinsman, Dr. James Lee, came in from Head of the River (Golden Spur) to: "reside in this city at the house of Mrs. Truman during the prevalence of the present malignant fever if his services are found necessary." From Westerly came Dr. Amos Collins to offer his services.

The epidemic raged through September, finally burning itself out in October. In eight weeks there had been 350 cases with 81 deaths. The disease was confined almost entirely within 1500 feet of the Parade. The greatest mortality was in Bank St. from the Parade to Golden St. Here, of 92 persons who remained during the epidemic only two persons escaped the disease and 33 died.

One merchant who came to this city only to transact business and stayed nights at Mr. Haughton's tavern in Montville came down with a fatal attack while there. Dr. Elisha Marvin of Norwich journeyed from that town to attend him, came down with the disease himself and died.

As an indication of the state of mind of the citizens, a contemporary account remarks: — "It may not be improper to remark that almost every person who remained in the central part of the city, particularly those contiguous to Bank St., or those whose business called them there, laboured under a high state of predisposition, being constantly affected with a slight and transient headache, a white furred tongue, and small shooting pains through the system. And those who came near this spot from other parts of the town very sensibly felt a difference in the state of the air producing in a greater or less degree some of these symptoms."

There was much speculation as to the origin of the disease. Noah Webster ascribed it to the exhalations given off by the spoiled cod-fish. This was in line with the theory of Benjamin Rush who felt that the Philadelphia epidemic had been due to the exhalations given off by a shipload of spoiled coffee. Dr. S.H.P. Lee in an article in the Connecticut Gazette thought that the infection might remain in bedding used by the sick, although he did not

consider the disease strictly contagious. He said that fever might arise from sleeping in beds used the season before. He was against laying the bedding in the sunlight as that might excite the infection to action. He also questioned whether burying the beds in the earth killed the infection. He thought that the contagious miasma adhered to the feathers.

After the epidemic we find an acrimonious debate being carried on in the advertising columns of the local paper concerning the superiority of Dr. S. H. P. Lee's New London Bilious Pills to the Windham Bilious Pills put out by one S. Lee, Jr. of Windham. Dr. S. H. P. Lee cautioned the public that the agents of S. Lee, Jr. of Windham were giving people Windham Bilious Pills instead of his New-London Bilious Pills.

Apparently Dr. S. H. P. Lee had some difficulty in collecting his bills for in the paper of June 12, 1799 we find that he: — "Once more and for the last time, calls upon those who are indebted to him on Book, and whose accounts are nearly outlawed, to call and settle them with Cash, Produce or their notes of hand.

Repeated Settlements make permanent friends.

For Sale at his Store. A few bbls. excellent Antigua Rum."

From 1798 to 1800 there are frequent advertisements for his bilious pills. They: — "remove an over-charge of bile in the stomach, bowels and biliary ducts." They are good for worms, gravel and dropsy.

In April 1800 Dr. S. H. P. Lee moved his office and store from State to Bank St. in the house formerly occupied by David Manwaring. In January 1801 he announced his unwillingness to inoculate "for the Variola Vaccina or cow-pox at present.", a practise that was then being introduced in New London by Dr. James Lee.

Most of the history of Dr. Lee has perforce to be taken from the newspapers of that period inasmuch as the records of the county society of that time contain very little relevant material. I can find no record of his having read any papers before the Society. As for the yellow fever epidemic it might never have existed if we look for any reference to it in the society records. The first reference to Dr. Lee in the records following his admission is in the notes concerning the meeting at Otis' Inn

in New London on September 25, 1804. He then asked to be dismissed from the society as he had been cited to appear before a committee of the State Medical Society in October to answer accusations against him. The nature of the accusations is not mentioned in the Society records but it may be inferred from an advertisement which appeared in the Connecticut Gazette for November 21, 1804, which reads as follows: — "At the annual convention of the Connecticut Medical Society on the 18th ult. the subscriber granted his permission to the members of said Society to make and administer in their own practise his patent New-London Bilious Pills. All persons not members as aforesaid are hereby cautioned against any infringement of his patent right upon penalties of the law. Signed — Samuel H.P. Lee, Member of Connecticut Medical Society." It is also noteworthy that no further advertisements of his remedies appear in the paper after 1800. It does not appear that he was penalized in any way by the investigating committee inasmuch as his name was carried as a member of the Society thereafter.

He acted as delegate to the state society several times between 1807 and 1819 and served as clerk of the society several years. As time went on his attendance at meetings became less frequent. In October 1828 he is noted as being excused from the payment of dues by reason of being over sixty years of age. He is last noted on the rolls of the society in April 1831. At that time there were 42 members of the society. The members from New London were Elisha North, Thos. Coit, Archibald Mercer, Dyer T. Brainard, N.S. Perkins, J. T. Sizer and James Morgan.

In 1838 he removed to New York where he made his home with his son, Dr. Henry Sullivan Lee. Here he died on January 7, 1863. His body lies in Cedar Grove Cemetery, New London, beside that of his wife and several of their nine children.

Of his personal appearance one can judge only from a portrait made after he had passed middle life. He was a man of large frame with rugged features. His forehead was high and straight and he had bushy over-hanging eyebrows and a bold straight nose which jutted out over a large thin-lipped mouth. It is the face of a man with good mental capacity and of great dignity.

He was a man of wide business interests which he conducted successfully. That he commanded the respect of his contemporaries is shown by the following extract from the pamphlet of Charles Holt on the yellow fever epidemic: — "Dr. Lee, to whose lot it fell alone and unassisted to combat the fury of the dreadful pestilence and his conduct on the occasion was such as will call the warmest sentiment of gratitude and esteem from the citizens of New London as long as the memory of the yellow fever shall exist in their minds. He exhibited heroic self-sacrifice and devotion. For a large part of the eight or nine weeks he carried the whole load."

That the respect of the laity was shared by his contemporaries in the profession is attested by the fact that he was several times elected delegate to the state convention and that on other occasions he was elected clerk of his county organization.

The sources of the author's information are the files of the Connecticut Gazette at the New London County Historical Society, the pamphlet of Charles Holt on the yellow fever epidemic at the same place, Frances Caulkins' History of New London, R. B. Wall's Appreciation of Dr. Samuel Holden Parsons Lee, published in the Anchor and owned by Mr. Ernest E. Rogers, and the records of the New London County Medical Association.

Thanks are due to Miss Elizabeth Gorton, secretary of the New London County Historical Society for her help in assembling material and to Mr. Ernest E. Rogers for the loan of material.

—☆☆—

DOCTOR FRED H. ALBEE HONORED

Doctor Fred H. Albee, International President of the International College of Surgeons, has been designated by Kappa Sigma, Greek letter college fraternity, as "The Man of the Year 1940."

The award is in recognition of Doctor Albee's service for the past 22 years as chairman of the New Jersey Rehabilitation Commission, which he helped establish, and for his achievements

CHEMOTHERAPY IN THE TREATMENT OF STREPTOCOCCUS EMPYEMA IN CHILDREN*

Grover F. Powers, M.D.
New Haven, Conn.

Since 1937, twelve children on the pediatric service of the New Haven Hospital, age 20 months to 16 years, with empyema caused by streptococcus hemolyticus have been treated with sulfanilamide or sulfapyridine. Five of these were also treated surgically. All patients recovered.

On the same service prior to 1937 in a series of thirty-one cases of streptococcus empyema in which chemotherapy was not used, only thirteen patients survived. Eight of the thirty-one patients were treated surgically.

—☆☆—

SULFATHIAZOLE AND RELATED COMPOUNDS*

Francis G. Blake, M.D.
New Haven, Conn.

The new sulfonamide derivative sulfathiazole appears to be at least equivalent to sulfapyridine in chemotherapeutic effectiveness in pneumococcal, hemolytic streptococcal, meningococcal, staphylococcal and gonococcal infections. It causes much less nausea and vomiting than sulfapyridine and is much less acetylated. It probably causes less frequent and severe untoward reactions, particularly with respect to the blood and the urinary tract. It would appear to be the drug of choice.

*16th Clinical Congress, New Haven, Sept. 17-19, 1940

in and numerous original articles on orthopedic surgery, especially bone grafting.

A bronze plaque was presented to Doctor Albee at the fraternity's annual founder's day dinner, December 10, in Washington, D.C., by United States Senator from Vermont Warren R. Austin, last year's recipient. Lowell Thomas had been the "Man" of 1933.

THOUSANDS HAVE SAID

"Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the \$37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2)

Rupture of the Uterus*

MAX L. BERLOWE, M.D.,
New Haven, Conn.

The Author—B.S., University of Georgia, 1930. M.D., Long Island College of Medicine, 1934. Assistant Attending in Gynecology and Obstetrics, Grace Hospital, New Haven, since 1938. Junior member, American College of Surgeons. Accepted as eligible for certification by American Board of Obstetrics and Gynecology.

Rupture of the uterus is one of the most serious obstetrical complications. It was first recognized and described by Guillemeau (1550-1613) and the literature since then has revealed many instances. With the improvement of obstetrical knowledge, and an understanding of the mechanism involved, the condition has become rare. It is now stated that rupture of the uterus should never occur in a well run clinic. This most certainly is true of the traumatic variety. In a series of 18 reports as published by Davis¹, the average incidence was 1:1194 cases; the extreme ratios being 1:300 and 1:6124 cases. In our clinic the ratio is about 1:1800-2000 cases.

We have had a series of cases that are illustrative of the various types of rupture. A study of these cases revealed the following facts:

1. Rupture of the uterus, as a complication of delivery, was not considered.
2. Rupture was due to the method of delivery.
3. Diagnosis of rupture was not made at the time of the accident or within 24 hours after the accident.
4. Certain signs and symptoms appear to be suggestive of a rupture.

The seriousness and danger of this accident to the life of the mother necessitates prompt recognition and immediate treatment. The diagnosis of the accident should be made immediately, or within 24 hours, and if this is done we may save these patients from certain death.

Classification of Rupture

Rupture of the uterus may be classified into

two groups, namely 1. spontaneous and 2. traumatic. The spontaneous group is the less common type of rupture and it usually results from some previous intrinsic myometrial disease. When this occurs during pregnancy, the lesion is almost invariably situated in the upper portion of the uterus, whereas rupture during labor is usually limited to the lower segment. Though this may be encountered in any period of a pregnancy, it is more frequent in the latter months. In the first half of gestation the accident is usually due to a pregnancy in the interstitial portion of the tube, in a bicornuate or infantile uterus, or to excessive invasion of the uterine wall by the fetal elements. In the latter half, the condition is associated with scar tissue (previous section), defective hypertrophy of the wall of the fundus, telangiectatic changes, hyaline degeneration, fatty degeneration, adenomyosis or over-distention.

In the traumatic variety, cases of rupture are due to factors which tend to strain the uterine musculature. Neglected transverse presentation, hydrocephalus, brow and posterior face presentations, large child, pendulous abdomen, pelvic tumors and the indiscriminate use of oxytocic drugs have been recorded as etiologic factors. While forceps and destructive operations may occasionally cause rupture, version for neglected transverse presentation, when this procedure is definitely contraindicated, is responsible for more ruptured uteri than all other operative measures.

Mechanism of Rupture

The mechanism of rupture was first described by Ludwig Bandl,² and it occurs in the following manner. Under the influence of labor pains the uterus becomes differentiated into two portions, an active upper, and a passive lower. These two portions become separated by a circular ridge of tissue called the contraction ring. The upper, by its contractions, serves to expel the child, while the

*From the Department of Obstetrics and Gynecology at Grace Hospital, New Haven. Read before the Staff of Grace Hospital, April 9, 1940

lower undergoes dilatation and passively forms part of the canal through which the contents of the uterus are expelled. When a serious obstacle is opposed to the passage of the child, the active portion of the uterus is stimulated to more forcible efforts, and powerful upward traction is exerted upon the passive lower segment which becomes more and more stretched and thinner and thinner. Often the anterior lip of the cervix becomes pinched between the presenting part and the symphysis. With this as a fixed point, the thinning and stretching of the lower segment is greatly enhanced. At the same time, the contraction ring separating the two portions becomes thicker and more prominent so that it can readily be palpated, and occasionally be seen as a transverse or oblique ridge extending across the abdomen just below or perhaps on a level with the umbilicus.

As the process goes on, the lower segment becomes extremely sensitive to pressure and the contractions increase progressively in frequency and intensity until eventually the upper segment of the uterus passes into a tetanic condition and no longer alternates between contraction and relaxation.

Physical conditions favoring rupture are thus established, and it is through this stretched, thinned and weakened lower segment that the catastrophe occurs.

Types of Rupture

The rupture may be complete or incomplete. In the complete variety the uterine contents are expelled into the peritoneal cavity, the rent extending from the uterine cavity through the mucosa, musculature and the visceral peritoneum. Complete rupture is by far the more common and occurs in about 80% of the cases.

In incomplete rupture, some portion of the contents of the uterus may be found resting under the enveloping peritoneum. The characteristic finding is that the uninjured or intact peritoneum is lifted from the musculature by the collection of blood or by the expelled fetus or placenta.

Hemorrhage

The concomittant hemorrhage is variable in amount. It is dependent upon the state of the vessels damaged. In complete rupture, after the extrusion of the fetus and placenta, the

uterus firmly retracts and further excessive hemorrhage is prevented unless large vessels have been damaged. In the incomplete type, the formation of a subperitoneal hematoma often develops and bleeding often persists slowly and steadily, the blood dissecting along extraperitoneal pathways.

Diagnosis

The diagnosis of impending rupture is based upon evidences of dystocia. The premonitory signs and symptoms as listed by Davis³ are as follows:

- "1. Prolonged labor with progressively stronger and more violent pains. Contractions may temporarily cease and then return in a short time and become agonizing in nature.
2. Acceleration in the pulse rate from 70 to 80 beats per minute to one of 120 to 160 per minute associated occasionally with an elevation in temperature.
3. Ascent of the contraction ring to a level between the pubis and navel, at times approaching the level of the umbilicus or higher.
4. General, exquisite, abdominal tenderness with marked tension of the lower abdominal region.
5. Excessive tension of the round ligaments causing them to stand out as tense firm cords.
6. Drawn and anxious facial expression of the patient showing an excessive degree of suffering.
7. Swelling and discoloration of the pinched vaginal portion of the cervix.
8. Gradual rise of the fetal heart rate in the intervals between uterine contractions indicating circulatory embarrassments as a result of excessive pressure from prolonged contractions."

The symptoms of actual rupture range in severity from the mildest disturbances to the most profound manifestations of shock and collapse. They may be summarized as follows:

- "1. Sudden sharp lancinating pain followed by cessation of active uterine contractions.
2. Shock. This is always associated with a change in the facial expression.
3. Bleeding — external and internal — the

amount of hemorrhage depending on the degree of vascular damage and the efficiency of tamponade afforded by the fetus.

4. Change in the contour of the abdomen caused by the expulsion of the fetus through the uterine rent.
5. In incomplete rupture, the formation of subserous hematoma and occasionally emphysema.
6. Recession of the presenting part from its position in the pelvic brim."⁴

Treatment

The treatment is definite. Once rupture has been diagnosed, immediate hysterectomy should be performed. Occasionally a repair of the uterus may be attempted, and if this is done, the ragged wound edges should be resected, so that tissue approximation is between smooth edges. The treatment, however, should primarily be preventive. We should never have a traumatic rupture. We should always remember that any case of prolonged labor presenting the premonitory signs and symptoms of impending rupture warrants immediate cesarian section, even though it appears that delivery from below can be easily accomplished. Often, the mere introduction of the hand into the vagina, may result in rupture. One cannot evaluate the amount of additional trauma the damaged lower segment can withstand, before terminating in rupture.

Prognosis

Most authors cite a 100% mortality for mother and baby in complete rupture without operation. With operation, the mortality is about 50% for the mother. In the incomplete type statistics vary from a 35% to 100% mortality.

Case Reports

CASE 1

C. F., 35 yrs. was admitted to the hospital complaining of abdominal pain of 2 hours duration. The pain was localized to the lower abdomen, was cramp-like in character and non-radiating. Nausea and vomiting was moderately severe. Patient was rational, not shocked, and cooperative. Her vital signs were within normal limits.

Her last menstrual period was four months prior to admission. She spotted for 2 days about 10 days before admission.

Examination revealed lower abdominal distention with spasm and rigidity. There was fullness in the flanks

with impaired resonance on percussion. On pelvic examination the cervix was found to be soft, exquisitely tender on motion and pressure. All vaults were found to be obliterated and tender.

A diagnosis of a ruptured extra-uterine pregnancy was made and at surgery the fetus was found extruding from the left cornual end of the uterus. A hysterectomy was performed, and the patient made an uneventful recovery.

This case is an example of a spontaneous rupture, complete in type and with concealed hemorrhage.

CASE 2

B. G., 40 years of age, was admitted to the hospital in active labor. Her gestational history was as follows:

1. 3 mos. abortion — before 1921
2. Full term living child — 1921
3. Full term still born — 1923
4. Full term breech — ?
5. 6 mos. miscarriage — 1932
6. Present pregnancy

Her vital signs were within normal limits. The duration of pains prior to admission was not recorded.

Rectal examination at 9 A.M. revealed the cervix to be 1½ fingers dilated. At 11 A.M. a vaginal examination was performed and the cervix was then found to be 4½ fingers dilated with the sagittal suture in the right oblique diameter. A diagnosis of an R.O.A. was made. (This obviously was incorrect, for with the S.S. in the right oblique there is either an L.O.A., or an R.O.P., presentation.) The pains which have been regular and strong became irregular and weak. At 4 P.M. the patient complained of sudden, excruciating abdominal pain and profuse vaginal bleeding occurred. A rectal examination was again done and the cervix was then found to be 2 fingers dilated, and the presenting part could not be felt. Abdominal examination revealed the fetus high in the abdomen with the fetal parts very easily palpable described as "just under the skin." No mention was made of the condition of the uterus.

Diagnosis of ruptured uterus was made. Surgery was immediately performed and a hysterectomy was done. The patient made an uneventful recovery. The rent was found to be in the lower segment.

This case is one of the complete types with external hemorrhage occurring during labor. This probably should be classified as traumatic, rather than spontaneous for the following reasons:

1. The progress of the case revealed a marked discrepancy between rectal and vaginal examinations.
2. A wrong diagnosis was made of position.
3. Dystocia was apparently present.
4. Ineffectual progress with a cessation of labor pains occurred.
5. Resumption of pains recurred with sub-

sequent rupture through the thinned lower segment.

CASE 3

A. L., 40 years old, para 11, gravida 12.

Patient was admitted to the hospital with an arm presenting. A midwife had attempted delivery at home using traction on the arm unsuccessfully. The length of labor and other details were not recorded on the chart. Examination revealed the patient in good condition, no evidence of shock was present, and there was no bleeding. The arm was swollen and discolored and the diagnosis of a transverse position with prolapse of an arm was made. Under deep ether anesthesia a version and extraction was performed. The placenta separated easily and the fundus was firm. This whole procedure only took 15 minutes. No difficulty occurred at anytime. The immediate postpartum condition was good.

One hour later the patient went into acute shock. She became cold and clammy, and her pulse and blood pressure were both unobtainable. The fundus was firm and there was no evidence of bleeding. Three hours later the patient was conscious, rational, cooperative and was taking fluids. The next day her blood pressure was 90/60, pulse rate about 100, the abdomen was distended, and the uterus was firm. However, she appeared to be very sick. Her color was gray, her eyes were sunken and she complained of lower abdominal pain. The next day her pulse rate was 118, temperature was about 102° and there was a suggestion of a tender mass in the left flank. Vaginal examination revealed a questionable mass in the left vault and the diagnosis was made of 1. bowel injury and 2. ? of broad ligament hemorrhage. The patient died on the following day, the vital signs having become progressively worse and the distention more marked.

At autopsy a large rent was found on the left side of the lower uterine segment extending completely through the wall of the uterus but not through its enveloping peritoneum. There was also retroperitoneal hemorrhagic infiltration extending up the extraperitoneal space on the left posterior pelvis.

This case is illustrative of the traumatic type of incomplete rupture with subperitoneal hemorrhagic infiltration, and illustrates also the difficulty in diagnosis which may be encountered.

CASE 4

S. S. 38 years, para 6, gravida 7.

Her gestational history was as follows:

1. 1922 — normal delivery at home.
2. 1925 — normal delivery at home.
3. 1927 — normal delivery at home.
4. 1928 — normal delivery at home.
5. 1929 — normal delivery at home.
6. 1934 — normal delivery at home.
7. Present.

Her pains started 22 hours before entry. The patient had been attended by a midwife who had ruptured the membranes 18 hours before hospitalization. Diagnosis was

then made of a breech presentation with the cervix two fingers dilated. The contractions were strong and regular, with an unusual firmness of the uterus between contractions. No progress was made despite these excellent contractions and a local physician had been called in. Morphine was administered and hospitalization was advised.

Diagnosis was made of an R. S. A. The cervix on rectal examination was thought to be two fingers dilated and the fetal heart was of good quality. An x-ray was ordered and the following is the rentgenological report:

"Sacrum is in an anterior quadrant. Fetal head is in the left upper abdominal quadrant.

While there were no measurements made of the pelvis or of the fetal head, it appears that the pelvic inlet is small and that the fetal head is of normal size.

On the A. P. abdominal film, there is noted a rounded shadow overlying the right lower abdomen which cannot be adequately explained unless one assumes that the fetus moved during the exposure and that there are two shadows of the head.

X-ray diagnosis, single pregnancy."

Vaginal examination was then performed, and the cervix was found to be between six and eight centimeters dilated. The cervix was very easily dilatable and a breech extraction was consequently decided upon. Ether anesthesia was administered, the frank breech was broken up with moderate difficulty, and the extraction was begun. Difficulty was encountered with the shoulders, and birth of the shoulders was obtained only after the anterior one was rotated through an arc of 180°. The head could not be delivered. Craniotomy was performed, the placenta separated and the uterus contracted firmly. A second degree laceration was obtained and this was repaired in the usual manner. The condition of the mother was good.

About four hours after delivery, the patient complained of pain in the back and on the right side of the abdomen. She voided spontaneously, her abdomen was soft and her general condition was good. The next day the patient appeared pale and gray and was rational. She complained of severe pain on the right side, her abdomen was moderately distended and her respirations were labored. The patient was coughing. The pulse was 132, T 101° and R was 28. The next day the patient appeared more exhausted and her lips and nail beds were cyanosed. She vomited and had a foul lochia. Her condition became progressively worse and she died two days later.

Post-mortem vaginal examination revealed a rent in the uterus which admitted a fist into the abdominal cavity and which was located in the lower segment on the right side.

This case is an example of a traumatic rupture apparently complete and with minimal hemorrhage.

Conclusions

We cannot do much to prevent spontaneous rupture, other than to carefully observe those women who have a history of myometrial disease. The symptomatology, diagnosis and

treatment are very definite and our course of action is sharply delineated. We have no mortality in these cases.

In our traumatic cases we have a mortality of 66%. These ruptures were due to interference from below. Our failure in preventing these ruptures was due to our not appreciating the significance of the premonitory signs and symptoms of this tragic catastrophe. Our failure in diagnosing the condition was due to the incorrect interpretation of the signs and symptoms which were present during the first 24 hours following the accident.

Discussion about the prevention of rupture can be brief. We must be aware of the premonitory signs, evaluate them properly, and terminate the pregnancy immediately by cesarean section, even though delivery from below appears to be a simple procedure. It is not amiss to emphasize again that the slightest manipulation in the vagina may tear the thinned lower segment.

If we prevent traumatic rupture, we will not have to diagnose it. Yet, the accident may occur and the accoucheur may not be aware of it. In that event and in order to handle the tragedy at the most opportune time, I believe that the uterus should be manually explored immediately following a version and extraction or a difficult breech delivery. If a rent is found, surgery can then be performed, and the patient be given an excellent chance of recovery.

If this is not done, and a rupture is present, the diagnosis will most probably be made at a time when surgery cannot be performed — as was exemplified in our two cases. However, these cases reacted similarly during the first 24 hours and this similarity, I believe, gives us a lead which may enable us in the future to save these patients from a certain death.

The shock, as expressed by the blood pressure and pulse rate, was not alarming. Yet, they presented that characteristic greyish pallor with deep sunken eyes, that we so often see in

the terminal stages of peritonitis. They had that clinical appearance of being very, very sick. Their looks belied their condition. This shocked appearance was outstanding, and was apparent to several different observers.

They both had a moderately severe, soft abdominal distention and both complained of pain on the side. We often see a soft distention following a difficult delivery, but it is usually not as severe as it was in these cases. Tenderness was definitely elicited on the side that the pain was complained of.

The pulse rate was slightly more rapid in both cases, being out of proportion, to the temperature.

These findings (considered together) of shock, of abdominal distention with one sided pain, and of an elevated pulse rate, appearing within the first 24 hours, should suggest the possibility of rupture. When this is present I also believe, that the uterus should be manually explored. This probably should be performed under anesthesia, and if a rent is found then immediate surgery should be considered. The extent of surgery should be governed by the condition of the patient. A supra-cervical hysterectomy, or a simple exteriorization of the uterus may be done.

There is added danger of infection following manual exploration of the uterus, but this risk must be taken in order to rule out a rupture. With proper technique, and with our present therapeutic measures, I believe we can combat this hazard. These patients will die if left alone, and no matter how radical surgery may seem, I believe they will at least be given a fighting chance to recover if the injured offending organ is removed.

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(SEE PAGE 2)

Treatment of Coronary Artery Disease*

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Excluding infectious involvement of the coronary arteries, as in rheumatic fever or narrowing of the ostia by syphilitic invasion, we may consider coronary artery disease to be synonymous with coronary arteriosclerosis. To diagnose this condition clinically, evidence of one of the following must be present: (1) angina pectoris, (2) congestive failure, (3) paroxysmal dyspnoea in the absence of valvular disease or of any other condition which imposes a greatly increased amount of work on the heart, (4) acute myocardial infarction, or (5) electrocardiographic evidence of myocardial damage in the absence of any other etiology.

We may accept the term angina pectoris to denote a syndrome consisting of paroxysmal, substernal, or precordial pain or discomfort of short duration, not infrequently radiating to the shoulders and inner aspects of the arms, precipitated by exertion, emotion or other states in which the work of the heart is increased, and relieved by rest or nitroglycerin.

During the past several years, we have been interested in studying the relationship between the clinical manifestations of coronary arteriosclerosis and the structural changes in the coronary arteries as disclosed by the extraordinary method devised by Dr. Monroe J. Schlesinger. Certain observations are directly related to the topic under discussion:

1. Obstruction to normal coronary arterial blood flow by arteriosclerotic narrowing or occlusion regularly results in the development

of anastomotic collateral circulation. This anastomotic collateral circulation serves as a by-pass around the obstructions and tends to nourish the myocardium which would otherwise be deprived of much or all of its blood flow.

2. Such anastomotic circulation compensates in part for the coronary narrowing or occlusion but does not do so entirely. The coronary reserve is clearly reduced.

3. The occurrence of arteriosclerotic narrowing or occlusion and the development of compensating collateral circulation are not necessary concomitants of the aging process. Hearts of even senile patients may have little or no coronary arteriosclerosis, and therefore no anastomotic channels. One third of all males over 50 show one or more occlusions without symptoms or signs.

4. In patients with angina pectoris the coronary reserve is greatly reduced, for the hearts of such patients are evidently unable to withstand continuance of work which demands increased blood supply. The incidence of old healed occlusions in such hearts is great and would not be borne by the patients except for the rich anastomotic circulation which compensates in large degree for such interference with blood flow.

5. The term coronary thrombosis is commonly used as a clinical diagnostic term to denote prolonged cardiac pain with signs of myocardial necrosis, i.e., fever, leukocytosis, increased sedimentation rate, progressive electrocardiographic changes and not infrequently the presence of shock. Since the term as it is commonly employed actually refers to acute myocardial infarction, this latter term is the more accurate one to employ. In accord with the observation of other investigators, one encounters instances of acute myocardial infarction in the absence of acute fresh coronary thrombosis. Conversely, acute coronary thrombosis may occur without causing infarction.

*Abstract of paper presented at the 16th Clinical Congress, Connecticut State Medical Society, New Haven, September 17-19, 1940.

Medicinal Treatment of Angina Pectoris and Myocardial Infarction

The object of medicinal treatment is to control the symptoms and functional disorders of the heart and circulation. There are no chemical agents that are known to influence materially the course of the structural abnormality in the myocardium or coronary arteries. The treatment of angina pectoris must be varied and adapted to fit the individual needs of each patient. In some cases an abnormality of the blood or basal metabolism or an unusual sensitivity to coffee or tobacco may be an important factor. In others, careful study of the patient's daily routine and contacts with people may reveal a constant relation between the occurrence of attacks and emotional factors, or habits of eating which may be avoided or corrected. Surgery may be advisable in a few. In most patients, however, the skillful use of drugs, singly or in combination, is of paramount importance in the treatment of angina pectoris.

The problem of drug therapy in angina has been the subject of many studies. A knowledge of certain characteristics of these drugs is of considerable practical importance in their clinical use.

The Nitrites

Nitroglycerin benefits some, does not help others, and aggravates attacks in a few. 1/200 grain hypodermic tablets are usually most satisfactory and are to be preferred when given by mouth. A test dose is advisable. Nitroglycerin has a prophylactic value in doses of 1/500 grain. The nitrites are not habit forming. Amyl nitrite has certain definite disadvantages. If used in the acute phase of myocardial infarction, the nitrites may precipitate dangerous ectopic tachycardias, collapse and death.

Xanthines

Theobromine sodium acetate (dose $7\frac{1}{2}$ grains) given four times a day is the equal of other theobromine preparations and the cost is less than one-third of most other preparations on the market. Theophyllin sodium acetate is as effective and may be given in a smaller size tablet. Since all theobromine and theophyllin derivatives cause nausea and heartburn when given in sufficiently large amounts, it may be necessary to use enteric coated tablets, administering one at bed time and some-

times an uncoated tablet in the morning. Strong cathartics are inadvisable as they prevent absorption of the drug. For cardiac infarction 4 grains of theophyllin ethylenediamine given slowly intravenously may stop pain.

Quinidine

This drug is useful in 5 grain doses four times daily in the treatment of angina pectoris, auricular flutter, paroxysmal auricular or ventricular tachycardia. Quinidine is also useful prophylactically in myocardial infarction with numerous ventricular extrasystoles.

Sedatives

Small doses of $\frac{1}{4}$ to $\frac{1}{2}$ grain of phenobarbital three times a day are of value in angina pectoris.

Morphine

One-quarter grain of morphine sulphate subcutaneously, repeated at one-half hour intervals, limiting the total to 1 grain in twelve hours is a satisfactory plan to follow. Morphine sometimes complicates the course of myocardial infarction. It promotes constipation with abdominal distention, and urinary retention through spasm of the bladder sphincter. It also causes vomiting, which may be repeated over a period of several hours. This violent muscular effort is a source of danger in myocardial infarction. Morphine renders the heart more susceptible to auricular and ventricular ectopic rhythms. Codeine in $\frac{1}{2}$ or 1 grain doses may be used in cases with mild pain. Dilaudid and pantopon have little if any advantage over morphine. For patients intolerant to morphine, a capsule of $\frac{1}{2}$ or 1 grain of codeine with 1/150 grains of scopolamine hydrobromide or with 1 grain of phenobarbital is often a satisfactory substitute. For pain resistant to other measures the administration of oxygen may be helpful.

Digitalis

The use of digitalis in angina pectoris and myocardial infarction continues to be widely debated. Most patients with myocardial infarction do not require digitalis. Patients with coronary arteriosclerosis not infrequently show partial heart block. This has been shown to be unaffected by digitalis in moderate therapeutic doses; hence the drug should not be withheld in the presence of positive in-

(Concluded on Page 156)

Depressive Reactions in Middle Aged Men*

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Depressive reactions occur very frequently in men between the ages of forty-five and sixty. This serious condition may exist for some time without being recognized, and in its incipency is likely to be passed over lightly by the patient's family and physician. There is a high incidence of occurrence and although there are no figures available, it may be a fair assumption that there are at least a hundred thousand acute cases and more than that number of chronic or residual cases existing in the United States at any given time. The condition is prevalent among able men at a time of life when they are carrying their heaviest responsibilities; therefore, its occurrence may not only be a personal disaster, but frequently has serious social and economic consequences. This painful, disabling illness may result in death, and even when self-destruction does not occur, the patient may become a chronic nervous invalid. For these reasons, this condition warrants careful study.

The depressions are evidenced in varying degrees of severity; some are relatively mild and others are decidedly severe. It would seem that each individual has a level below which he does not descend; having reached this level, the condition remains stationary, and does not become more severe except insofar as discouragement increases as recovery is delayed. Even the mild depressions are both painful and handicapping and the more extreme ones cause severe suffering.

Practically all physicians are called on to treat this condition, yet at the present time there is no unanimity of opinion as to its cause or treatment. Some say it is a manic-depressive reaction; others attribute it to arteriosclerosis, vitamin deficiencies, or glandular changes. Many physicians merely suggest a trip, while others recommend psycho-analysis. This condition is sufficiently prevalent to enable us to pool our experiences that we may understand it better.

The depressed states experienced by men over forty are commonly said to be analogous to the involutional depressions of women. It is perhaps more accurate to say that both men and women may have middle-aged depressions and that the condition must be more carefully studied in both sexes before scientific comparisons can be made. It would seem that in the case of men this is not a disease entity; it is, rather, a clinical syndrome, representing a psycho-physical reaction due to a combination of factors.

Onset: It is difficult to fix the time of onset, since it is usually gradual and unrecognized. The precipitation of acute discomfort is likely to follow a physical illness, change of environment, prolonged emotional strain, or a marked alteration in the patient's way of living. The actual onset has usually passed unnoticed by the family and associates until they review the situation in retrospect; it is then seen that there has been a gradual and progressive exaggeration of the patient's usual personality difficulties. The family are likely to say, "He was always like that, only he is ten times worse now." In some instances men with considerable pride are able to conceal their illness from family and business associates until it is rather suddenly realized that the individual has become completely useless. In such circumstances the patient may lose his job or be retired because of incompetency, the onset

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†Silver Hill Foundation for Functional Disorders New Canaan, Connecticut

having been so gradual that neither the patient nor his associates realized that he was truly sick.

Symptoms: The picture is usually typical. The symptoms may be divided into those which are constant, that is, nearly always present, and those which are variable but frequently present.

Constant Symptoms:

Anxiety, either in the form of frequent attacks, or else, constantly present. It is usually much worse in the early morning.

Irritability.

Restlessness.

A sense of mental fatigue, and a decrease of mental vigor.

Difficulty in concentrating, so that reading is difficult or impossible.

A general loss of interest.

A flattening of mood, there are no emotional high lights, he does not care for anyone or anything.

Increased emotional variability. Unusual sentimentality and dependence, with rapid changes of mood to irritation and unwise independence. The family and associates never know what to expect next.

Preoccupation with self.

Insomnia, usually evidenced as awakening early in the morning.

A sense of futility and general hopelessness.

Increased emotionalism. The patient is unduly affected by music, poetry, moving pictures, newspapers, as well as the real and imagined emotions of others.

Decrease or loss of sex interest.

Variable or Inconstant Symptoms: The following symptoms may or may not be present. It is noticeable that in this condition all the symptoms are likely to be variable; the clinical picture may change from hour to hour. The patient may be very ill in the morning and feel well in the afternoon, — he may be horribly uncomfortable for a period of days and then have a day when he feels perfectly well.

A decrease in physical endurance.

Physical symptoms related to the digestive system, discomfort referred to the heart, tremors, dizziness, dry mouth, foetid breath, increased perspiration, frequent urination, constipation, vague aches and pains, and slight

but temporary incoordination.

A tendency to neglect responsibilities.

Indecisiveness.

Suspiciousness.

A wish to be alone: the patient is apt to retire early, that he may get away from people.

A sense of unreality, or feelings of separation from the environment.

Impulsiveness.

Tantrums and hysterical attacks.

General dissatisfaction with self and attainments.

A sense of being lost, often expressed as being "finished" or "washed up."

Fear of insanity. This is a frequent symptom of serious consequences.

Lost of interest in living and frequently suicidal obsessions.

Nightmares — dreams portraying disaster, failure, death, and futility.

These patients may seek relief from discomfort through the excessive use of alcohol, tobacco, or food, so that temporary alcoholism may be a complicating symptom. Most of those who turn to alcohol discover that its use increases their discomfort. They may then give up alcohol, tobacco, and coffee and turn to strange dietary habits as they search for means of relief.

In the midst of his illness the patient may have periods of feeling better. These are short spurts of well-being or periods of actual elation, during which he frequently acts unwisely and after which he usually falls back into his former agitated depressed state.

To summarize the symptoms, — here is a clinical picture of a depression, varying in its severity, which is marked by agitation, a lowering of physical and mental endurance, rapid fluctuation of mood, a tendency to hypochondriasis, and frequently complicated by neurotic mechanisms.

Cause: It is safe to say that the cause of this condition is not known. It occurs principally in a man with a certain type of personality, and there are significant similarities in both the early background of these individuals and their habits of living.

Physical factors: General physique does not seem to play a part. There is no proof that it is due to a change in the sex glands or any other gland of internal secretion. The theory

that these depressions are the result of involutonal processes in the sex glands remains to be proven; it can be considered at present to be no more than a supposition.

Many of these patients are below par physically, without evidence of serious organic illness. They are apt to be underweight, with poor muscle tone. A number of them evidence an overactive or disturbed autonomic nervous system.

Arterio-sclerosis with its accompanying high blood pressure is not infrequently present. This fact lends some support to the supposition that these depressions may be due to prematurity aging. It is certainly true that the greater the degree of arterio-sclerosis, the lower is the level of the patient's functional recovery, the less strain can he carry after his condition improves.

To recapitulate, physical depletion, a life-long tendency to minor disturbances of the autonomic nervous system, and arterio-sclerosis are the only physical findings which occur sufficiently frequently as to suggest that they may play a part in the picture.

Personality and temperament: It is impossible to describe by an accurate generalization the basic personality reactions of all these patients, but the condition is most likely to occur in the following types of individuals: They can be described as manic-depressive introverts who have frequently shown a tendency to neurotic reactions prior to this illness. They have moderate or superior intelligence with single-track minds, and they hold unswervingly to their purpose. They are extremely sensitive and have always been very apprehensive. They possess more than the average amount of drive, will not tolerate interference, are usually abnormally ambitious and react badly to frustration. They are poor losers who do not enjoy competition unless they can win. They have not a very active sense of humor. They have many acquaintances but few real friends and so are apt to be lonely people who go their way without seeking guidance or advice from others. They are, therefore, almost abnormally dependent on the few people whom they love and who will take the trouble to love them. Many, not all, have rigid personalities.

Frequently these patients are self-made men who have risen from relatively meagre economic and social backgrounds and, impelled by

maternal ambition and poverty, are determined to fight through to a position of economic or social prestige. One gets the impression that some of these people have stretched themselves too far or for too long in order that they may attain or maintain a desired goal. They have lived too long on what might be called an emergency program, giving little thought to balancing their lives in terms of work, rest, exercise, and play. Many people in times of emergency are capable of a twenty to forty per cent temporary increase in effort and attainment, but few can maintain such a level for very long. These men attempt to live steadily on this emergency level.

The personality patterns of patients afflicted with this disorder might be summarized as those of dynamic, apprehensive individuals with severe inferiority reactions, partially compensated by prolonged and unusual efforts to attain outstanding superiority.

This is not an attractive picture and these are not comfortable personalities either to possess or to live with, yet these men occupy many of the key positions in our society. As a rule, they are not the top men; they are next to the top, both in position and ability. Sometimes they work so hard that they resent not being at the top, not realizing that to hold the very top positions for a long period of time demands effortless superiority. They are able people, but they are apt to think that they are more able than they are.

A basic causative factor in this illness is one which is common to many forms of nervous illness, only it is more clearly exhibited as a causative factor in the depressions of middle aged men. It would seem from the psychogenic standpoint that nervousness may be the result of accumulative frustrations of aspirations, accompanied by a break-down in the compensatory mechanisms. The more aspirations an individual has, and the longer he lives, the greater is the accumulation of frustration. The more ambitious these aspirations are, the more single-tracked the person becomes in his activities, and therefore the fewer are the sound compensatory mechanisms developed. These frustrated aspirations may have to do with ambition, desire for importance, social preeminence, financial security, family relations, sex, physical strength, and personal

development of character. Finally the accumulation of such frustrations of life-long aspirations becomes too great a burden for the individual to carry comfortably or to carry at all.

Treatment: Therapy in this condition has three aims: to prevent suicide, restore the patient to a state of comfort and usefulness, and try to prevent a recurrence.

These men frequently commit suicide, particularly if their illness has lasted months or years and the patient has become convinced that his condition is hopeless. The danger of self-destruction is very much greater if the patient suffers from a serious organic complication. If genuinely suicidal he must be thoroughly protected until that phase of his illness passes. Most of these patients are not actively suicidal; for such, commitment is usually contra-indicated, and they are best cared for either in the community or in a special nursing home.

It is frequently stated that as the patient begins to recover he possesses more initiative and so is more likely to commit suicide. Therefore, a sudden and unexplained improvement indicates that the patient should be more carefully watched.

Physical Care: Faulty habits of living must be corrected. The day should be regimented from the time the patient gets up until he retires, and he should not retire too early. These people need a moderate amount of pleasant exercise, they should do some work, as well as read, be with people, and play games. Exercise gives some relief from symptoms and hastens recovery.

In many instances it is necessary for the patient to continue with his regular work. When this is true he must step up to the job and put everything he has into it for a few hours each day. He should stop work in the early afternoon, plan pleasant things for the rest of the day, and arrange for diversion in the evening. If the patient must continue with his work, it helps for him to have short trips and refreshing experiences at frequent intervals, — it gives him something to look forward to. It is a mistake for these men to continue with their work unless they do it reasonably successfully.

At times a prolonged vacation from work,

taken away from home, is indicated. But all too often this fails. Merely to prescribe a trip or a long vacation is not enough; it must be a vacation under favorable circumstances and frequently preceded by a short course of mental hygiene reeducation. Most of these men are badly adjusted individuals who carry their personality problems with them. Some men with a mild depression do profit by going on a trip. Freedom from worry, pleasant new experiences, a chance to harden up physically, and an opportunity to regain perspective do the trick in some, but not many cases.

The physically soft patient needs to be gradually hardened up, and if underweight, his weight should be brought up to his normal by the use of appropriate diet, vitamins, and tonics. Usually as the patient gets better he puts on weight; it is hard to decide which is cause and which is effect. Barbituates are best avoided during the day; they are depressing, and if they must be used, reserve them for the night when they will do the most good. The patients should be given restful nights. Ten grains of medinal, three grains of sodium amytal, or three grains of nembutal at bed time are apt to accomplish this. Seconal in doses of grains one to three is useful to combat early morning wakefulness and anxiety. Benzedrine sulphate does not seem to help very much but is worth trying; in about fifty percent of the cases it increases the patient's agitation, and when this occurs, it should be stopped.

It is doubtful if hydro-therapy or physiotherapy is indicated with most of these patients, since we want to direct their attention away from themselves, and there is no reason to believe that either hydro-therapy or massage actually hastens recovery. Instead, it is better to give them normal exercise with people under pleasant conditions. Bromides given symptomatically help.

In the present state of our knowledge, glandular substances and other drugs possess only suggestive value and only as such may be an important part of psychotherapy. I have used large and frequent doses of testosterone propionate without being convinced that the substance itself was an active agent in bringing about recovery or relieving symptoms. I have had very little experience with "shock therapy" in these cases. The experience I have had

causes me to question its efficacy and to believe that it is contra-indicated in depressions occurring in middle aged men.

Other psychiatric treatment: This consists of psycho-therapy first directed to meet immediate needs and later to correct or modify personality reaction patterns. In addition it is necessary to make plans for and to help the individual find means to adopt a wiser and more satisfactory way of living. These patients must cease trying to be super-men; they must learn to be willing to live within the limits of their abilities. They must substitute skill for effort, and ordinary every-day happiness for ambition.

The first step in psychotherapy is to make the patient comfortable. To do this, interpret his illness as the usual and normal reaction to fatigue and emotional strain. Give him positive reassurance, both as to recovery and relief from symptoms. Discount his self-accusatory ideas by reminding him of his attainments and persuade him that this is merely an illness which is to be taken in his stride as he would a bad cold. It is wise to remove the patient from the environment which is accentuating his difficulty, to place him in an emotionally neutral environment, and to insist that temporarily he drop consideration of his immediate problems. The purpose of all this is to remove strain, decrease discomfort, induce confidence, reduce the danger of suicide, and to make the patient hopeful. In this way the emotional trauma to the sympathetic nervous system is decreased, symptoms subside, and the patient is given a better chance of recovery.

As previously indicated, these patients should be put on a definite schedule which will keep them occupied in pleasant pursuits. They should keep in touch with other people and be encouraged to continue with or to resume recreational activities which they have enjoyed in the past. They should not be left alone to brood over their troubles and may need a psychiatrically trained attendant. In some instances, a suitable member of the family can serve as a companion, but to do so is usually a strain on the person who undertakes the job. These men are to be kept busy, encouraged to find entertainment, reassured and comforted. They are very suggestible and this is no time

to point out their faults; they are sick people who do not need to be scolded. Instead of long discussions and good advice, give them slogans which they can hang on to. These help at least temporarily, so much so that it is almost pathetic to see how avidly the patient will seek and repeat comforting phrases. All this has to do with the initial comforting and reassuring phase of psychotherapy.

When the patient with a middle age depression consults the psychiatrist, he is apt to be suffering from two conditions: first, a depression, and secondly, an neurotic attitude towards the depression. Most of them are basically neurotic and many have had neurotic illnesses prior to becoming depressed. Therefore, when the patient is more comfortable, the next step is to dispel the neurotic attitude, insofar as it is possible to do this without increasing anxiety. This is done by explaining the nature of his illness, proving that it is not a serious condition and insisting that he temporarily accept his depression as he would any other illness. He is then to be taught and trained how to deal with a neurosis. To do this, the attention must be directed from his symptoms and he is to be helped to substitute useful emotions for harmful ones, thus learning to live a more normal life even though he is depressed, without agonizing about his condition. All this means that the physician pursues a constructive reeducational approach towards the relief of the neurosis complicating the patient's depressed state. As the individual's attitude towards his illness becomes less neurotic, the clinical picture may change, inasmuch as the patient may seem fifty percent better and many of his symptoms disappear. The decrease of the neurotic attitude does seem in many cases to facilitate the lifting of the depression. This striking primary improvement may lead the patient, and sometimes the doctor, into the error of expecting a rapid recovery.

The depression itself is commonly said to lift in time. Many physicians consider that little can be done to relieve a depression but to protect the patient and wait for him to get well. There is an element of truth in this, inasmuch as with the passage of time most of these patients do come out of their depression; many of them, however, have recurring depressions alternating with mild elations. All too fre-

quently the story is that the patient comes out of the depression, returns to work, goes into a mild elation, and then has a more severe depression. Sometimes there is a series of such episodes, the subsequent depressions occurring more frequently and becoming more severe. Finally some of these patients pass into a state of chronic hypochondriacal depression.

It is a good psycho-therapy to tell the patient that these depressions always lift, that he must be patient, bide his time, shorten sail, batten down the hatches, point into the wind, and ride out the storm, knowing that he is secure in a good harbor. But we doctors must not put our faith in time alone curing such patients; instead, we have a major therapeutic procedure on our hands, namely, the mental hygiene re-education of the patient together with the making of plans and finding means for the permanent readjustment of the individual. We must remember that most of these patients have attempted to stretch themselves beyond their capabilities. This may be either a physical or emotional strain, but it is usually emotional. Frequently the patient sees that he is not going to be able to reach the goal which he has set for himself, and either the fear of failure or the knowledge of frustration is more than he can stand without becoming ill. Such attitudes and situations are not easy to correct, but in many instances much can be done. The therapeutic aim is to help these men to be reasonably comfortable and at least moderately useful. If properly handled, many of them can be returned to a reasonably full life. To do this, the following steps are necessary:

First, determine the original capabilities of the patient prior to his illness. This means physical strength, energy—expenditure, intelligence, emotional stability, nature of training and education, together with the level and ease of performance. In judging this, watch out for one possible error: did the patient have to strive unusually hard, that is, was he using everything he had, or did he accomplish his objective easily?

Second, try to estimate how much he has been injured by this experience, and to what extent he has aged, physically, intellectually, and emotionally. How sound are his recuperative powers?

Third, based on his past performance and present condition, how much work can he do now, what form of life would be best for him

and how can this be adapted to his circumstances?

The physician must take a firm stand in treating this condition. He instructs the family, comforts and reassures the patient, corrects neurotic attitudes insofar as it is safe to do so, and tries to give these basically badly adjusted individuals a more wholesome, workable point of view. In addition he advises the patient to live within the limit of his present capabilities.

Prognosis: Most of the middle aged depressions get better, some make a complete recovery, many get much better but remain somewhat handicapped. The latter are for all intents and purposes well, but they lack the "come back," the degree of flexibility and some of the energy they possessed prior to their illness. The following seem to be favorable prognostic factors.

1. The younger patients do better than the older ones, provided they can be induced to adopt a wiser point of view and way of living.
2. The absence of physical disabilities.
3. The absence of serious family complications.
4. A reasonably interesting job which does not keep the patient under a heavy emotional strain; such patients are better off with a job than without one.
5. Sufficient income to live on.
6. A wise, kind and, understanding relative, preferably a wife or child, who will carry on where the psychiatrist leaves off. It may take years for these men to make a comfortable compromise with life, and frequently this occurs through the medium of wise, affectionate guidance.

Little is actually known as to the prophylaxis of this condition. Perhaps in a less competitive form of society it might be less likely to occur. In the meantime, until such a Utopian form of society exists, the overly serious, too ambitious, dynamic introvert should be taught to understand himself and to good-naturedly laugh at his own painful strivings. Work he will no matter what we say, but he must have other compensations in life besides work. He needs hobbies and he must learn to play. This type of individual usually has great pride of accomplishment and so can be taught to take pride in his hobbies and diversions as well as in his work. It would seem that play in large doses is the best antidote for the middle age depressions.

State Aid to the Blind in Connecticut

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The Old Age Assistance law was passed in July 1935 and in 1937 Section 617e was added to extend financial help to the blind. This section reads as follows: "Aid to the Blind. (a) The provisions of this chapter (the law relating to Old Age Assistance) are extended and made applicable to needy blind individuals, regardless of their age, who in other respects comply with the provisions thereof. (b) Blindness shall be defined to mean total and permanent loss of sight in both eyes, or the reduction to one-tenth or less of normal vision with glasses." Since this problem was quite different from that of the Old Age program considerable ground work had to be done before the plan could be actually put into operation. The program was finally launched on January 25, 1938, under the supervision of Mr. Edward H. Reeves.

A Consulting Ophthalmologist was appointed to review reports of the ocular examinations of applicants for aid and to advise and work with the Bureau in Hartford. A voluntary advisory committee of ophthalmologists, composed of Doctor Edward N. De Witt of Bridgeport, Doctor Walter L. Hogan, of Hartford, and Doctor Herman C. Little of New Haven, gave valuable assistance in formulating plans and procedures from the medical standpoint. Now that two and a half years (to July 31, 1940) have passed, it has seemed worth while to review the cases and the experiences of the examiners and to attempt to read the lessons which may be learned so far, both as to the expediency of the program and the ophthalmological data presented.

The Bureau of Old Age Assistance has re-

ceived a total of 364 applications for Assistance to the Blind of which 21 were re-applications, making a net total of 343. At the age of 65 a blind person automatically passes over into the Old Age Assistance group. The number of applicants examined by the ophthalmologists was 276, the difference in figures being due to the fact that many applicants for aid were either too old, had sufficient financial resources, the vision was not sufficiently lowered, or for other reasons were not eligible, and hence were not referred to the ophthalmologist for examination.

All qualified ophthalmologists in the state are eligible to be placed on the list of examiners, and the applicant is free to choose from the list of examiners in his vicinity. The examiners were at first paid a fee of five dollars for each examination; later it was thought that a blood test for syphilis should be made a part of the examination, to help determine the relationship of syphilis to blindness, and for this test an additional fee of two dollars was allowed. Recently the reporting of the blood test has been made obligatory, since the bureau feels that the work of the department should be not merely one of financial help to the blind, but that we should have a wider outlook and consider the program as one of sight-saving and preventive work.

The first case to be examined by an ophthalmologist was on Feb. 2, 1938.

Age. From birth to 10 years . . .	8
From 11 to 20 years . . .	14
From 21 to 30 years . . .	38
From 31 to 40 years . . .	42
From 41 to 50 years . . .	61
From 51 to 60 years . . .	63
From 61 to 70 years . . .	49
From 71 . . .	1
Total	276

From the accompanying table it is readily seen that the greatest number of applications were between 40 and 60 years of age, the two decades, 41-50 and 51-60, being almost equal.

The next highest number was in the 61 to 70 group. This is to be expected since glaucoma, cataract and degenerative diseases affecting the eyes are more prevalent during the later years of life. The youngest applicant was 4½ months old and the oldest 71 years.

Sex. There was no great difference in the percentage of cases between male and female, the former being 147 and the latter 129. The greater exposure to accidents undoubtedly accounts for the greater number of males.

Results of Blood Tests for Syphilis. Blood tests were reported upon in 150 cases and no reports were made on 126. The latter were principally the early cases when the test was not asked for. Of the 150 cases reported there were 29 positives, an incidence of 19.4%. This is a relatively high percentage of syphilitics, but does not, of course mean that the blindness was necessarily due to this infection. Blindness resulting from an explosion, for instance, could not be considered due to syphilis, even though the individual were syphilitic. One known syphilitic with optic atrophy had a negative reaction, but in 22 of the 29, syphilis was clearly the cause of blindness.

Eligibility for Aid. Of the 276 cases examined 26 were found not eligible because the vision was better than the minimum which constitutes blindness (20/200). This was rather surprising and gratifying, since one might suppose that many persons with only one eye, or with defective vision in both, would attempt to secure the financial aid available to the blind. Very few instances of malingering were encountered and a spirit of fair play has been manifest among the applicants, the examiners and the Bureau officials.

Diagnoses. Perhaps the most interesting part of the review of the cases examined is that relating to diagnosis. It must be understood that no agreement between the number of different diagnoses and the number of cases examined is possible, since one individual may have had several different conditions, each of which could have caused the disability. Thus, a person might have a corneal ulcer with resulting scar in one eye, and glaucoma and cataract in the other, therefore all three diagnoses would enter into the picture of blindness in one applicant. So far as possible the diagnoses are made under the particular structure of the eye affected.

CORNEA.

opacities	16
leukoma	6
interstitial keratitis	11 (One due to acquired syphilis)
staphyloma	3 (1 ophthalmia neonatorum.)
keratoconus	2
sclerosing keratitis	2
ulcus serpens	1

IRIS AND CILLARY BODY.

iritis	4 (1 tuberculous)
iridocyclitis	14 (1 post-operative, 1 syphilis, 1 trauma)

LENS.

Cataract	
senile	24
congenital	22
dislocated	9
secondary	2
traumatic	2
juvenile	1

VITREOUS.

Hemorrhage	1
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RETINA AND CHOROID.

retinal detachment	14
embolism central artery	1
retinitis pigmentosa	7
chorio-retinitis	20
syphilis	5
diabetes	4
arterio-sclerosis	2
metastatic	1
measles	1
hemorrhage	1
albuminuric	1
cerebro-macular degeneration	1
trauma	1
senile	1
undetermined	2

OPTIC NERVE.

Optic atrophy	
cause undetermined	17
syphilis	11
congenital	7
brain tumor	5
whooping cough (?)	1
meningitis	1
fractured skull	1
secondary anemia	1
"blood clot"	1
hemorrhage	1
measles	1
wood alcohol	1
cavernous hemangioma of orbit	1
focal infection-tonsils	1

AFFECTING THE GLOBE AS A WHOLE

Panophthalmitis 2 (1 post-operative, 1 injury. phthisis bulbi 12 (ophthalmia neonatorum 7, post-operative 1, chemical burn 1, accident 1, syphilis 1, unknown 1.) ruptured globe 2 (intra-ocular foreign body 1, gasoline explosion 1). glaucoma 35. (chronic, simple 32, secondary 2, acute congestive 1). enucleation 18. (post-operative 5, intra-ocular foreign body 2, injury

3, explosion 1, myopia 1, corneal ulcer 1, shot in eye 1, ophthalmia neonatorum 1, bilateral, cause unknown 1, cause undetermined 2) sympathetic ophthalmia 15. (penetrating wounds 6, post-operative 3, intra-ocular foreign body 3, ulcus serpens 1, explosion 1, cause unknown 1).

refractive errors, myopia, 14.

CONGENITAL DEFECTS. 31

Cataracts 22, multiple defects 5, albinism 3, amblyopia with hyperopia 1.

Conclusions

While the number of cases examined is not great and the percentages of the different causes of blindness cannot be taken as an accurate gauge throughout the country as a whole the results of the review are interesting to the ophthalmologists, members of the bureau of Aid to the Blind, and to the social workers. It seems possible to draw several conclusions from the analysis which may stimulate us to better results in the treatment of sick and injured eyes. Perhaps the most striking feature is the high percentage of sympathetic ophthalmia, 15 cases, or 5.4%.

Since the most dreaded of all eye afflictions can be prevented by the removal of the injured eye if done early enough, the lesson seems evident that we should not temporize with the injured and dangerous eye in the hope of saving a useless member.

A second striking observation is the number blinded by congenital cataract, 22 or 8%. Many of these cases were operated upon repeatedly and unsuccessfully. Granting that the poor results are often due to the fact that other congenital defects are present in the eye with cataract, we should strive for better surgical procedures in dealing with this condition. Senile cataract would naturally loom large in a statistical study of a group largely beyond middle life, these being 24, or 8.7%. Some of these were operable but occurred in one-eyed individuals who declined to risk what little vision remained to them.

Glaucoma represents a percentage of 12.6% and testifies to the lack of early attention on the part of the patient, to the failure by the physician to recognize incipient cases, and to the inadequacy, to date, of medical and surgical treatment of this baffling condition.

Six cases (2.1%) of ophthalmia neonatorum are responsible for blindness. This, with 30 known cases of syphilis, charges the social

diseases with 36 cases of blindness, or 13% of all the applicants. Here, certainly, is a field for preventive medicine to help eliminate one eighth of the blindness represented by the group studied.

It is a pleasure to record the close association of the work of the Bureau and that of the State Board of Education for the Blind. These two organizations are entirely independent, but each aids and supplements the other. This is evidenced by the fact that of the 276 cases examined the Consultant has received reports from the State Board on 64, in one case as many as six letters being received.

The Consultant expresses his thanks to Mr. Reeves, Director, Miss Mary Turner, State Supervisor, and to Mr. Stetson K. Ryan, Secretary of the State Board of Education for the Blind.



MEDICALLY PRESCRIBED CONTRACEPTION

The comparison of twenty-five criminal abortions after use of scientific contraception with 127 before, in a group of 500 private cases, indicates the ability of medically prescribed contraception to decrease the number of criminal abortions to one fifth, with subsequent prevention of maternal ailments and possible sterility, Marie Pichel Warner, M.D., New York, declares in *The Journal of the American Medical Association* for July 27 in an analysis of the cases. The majority of abortions occurred in married women, she says.

The women in the group were of middle class New York City families of different religious denominations. All but three of them were white. Half of the group, Dr. Warner reports, stated that inadequate income was their main reason for wanting to avoid further pregnancies. "The majority of women," she continues, "sought contraceptive advice during the first year of marriage, the remainder from one to thirty years after marriage. The trend among the younger group is toward obtaining contraceptive advice premaritally. Every 'premarital' couple, of which there were 132, expressed the desire for offspring in the future. They felt the need for temporary contraceptive advice and wanted assurance the method would not cause sterility."

Synovial Sarcoma

Case Report

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and

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The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the *Journal*. The following from the Mt. Sinai Hospital (Hartford) is the third in this series. (The Editor.)

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1923 to date. Chief of staff, Mt. Sinai Hospital,
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geons.

Dr. Schaefer — Ph.B., 1921; M.D., 1925, Yale.
Pathologist, Hartford Municipal Hospital, 1929-30.
Assistant Visiting Physician, Hartford Municipal
Hospital, 1931-1938. Pathologist, U.S. Veterans'
Hospital, Newington, 1931-1939. Pathologist, Mt.
Sinai Hospital, Hartford, 1930 to date.

Malignant tumors of the joints, bursae and tendons may be classified into one of two groups: (1) that of fibro-sarcoma and (2) that of synovial sarcoma. Synovial sarcoma is a rare form of malignant tumor of the extremities. It may arise outside of and far from articulations or in the midst of soft tissues, where it may originate in a serous bursa, normal or irregular from an anatomical point of view. The following case illustrates a type of synovial sarcoma.

The patient was a ten year old Polish girl whose chief complaint was "swelling over the right buttock and inability to walk." Some time before admission she had received two intra-gluteal injections for "anemia." Following the second injection a painful swelling was noted in the right buttock. She was treated locally for a short time but, because of no improvement, her family consulted another physician who advised immediate hospitalization. Physical examination revealed a swelling in the region of the right buttock about the size of a pineapple. The skin over this area was not reddened or discolored but it had an "angry" appearance. On the surface was seen a network of veins. The mass felt hard but was not painful to palpation. The age of the patient and the rapidity of the growth suggested a diagnosis of sarcoma. The elevation of the temperature and the leucocytosis

were interpreted as a manifestation of neoplastic degeneration. The patient was operated on August 1, 1940.

Operative Note

A 4½ inch incision was made over the mass. The fascia was incised; muscles were found degenerated and free fluid with particles of tissue were found in the wound. This fluid was aspirated. The neoplasm was enucleated by dull dissection. Mass appeared fairly hard. Bleeding was controlled. There was some oozing present deep in the cavity. This was packed with gauze and the layers sutured around it. Pressure bandage was applied.

Pathological Report

MAC: Specimen removed from buttock measured 10 x 7 x 3 cm. It was firm but not unusually hard. It was somewhat nodular externally. On section a smooth gelatinous grayish-white surface containing some yellowish-chalky islands were noted. On cutting, the tissue was very soft.

MIC: Examination revealed an infiltrative growth composed of round and ovoid cells exhibiting anaplasia and mitotic figures in moderate abundance. Most of the cells were round or ovoid and the infiltration occurred in columns in some places and in nests in others. There was a suggestion of papillary arrangement in some places and small spaces were noted surrounded by columnar or cuboidal

cells in single layers. These latter were interpreted as of synovial origin. Most of the cells were immature and appeared to be that of sarcoma arising from the synovial tissue of a bursa.

The child was discharged from the hospital to the care of her physician in a nearby town. There she developed symptoms referable to her pulmonary system which caused her death within a month. In all probability there were pulmonary metastases. No autopsy was obtained.

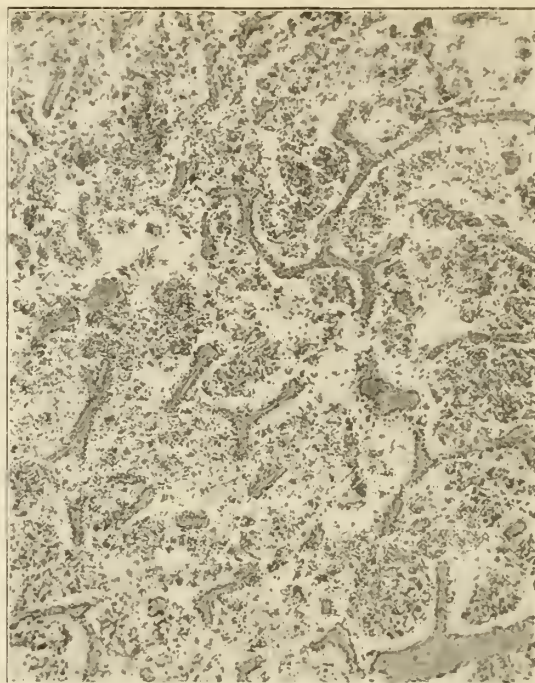
Discussion

It is only recently that attention has been called to this type of tumor and it is quite likely that its occurrence is not quite as rare as a survey of the literature would indicate and that the characteristic nature of some cases has been overlooked and they have been classified as other types of neoplasm. According to Berger's survey of the literature he identifies 23 cases in all presenting specific synovial features of which 11 are articular, 9 in bursae and 3 in tendon sheaths. 16 of these cases were without doubt histologically and clinically malignant.

As Berger has well said: "Critically reviewing the literature and taking into consideration our own observations, we are led to the conclusion that only those tumors are specifically synovial in which there appears one of the morphological or functional characters pertaining to normal synovial membranes. These characters are essentially (1) reticulo-histiocytis, (2) endothelial or (3) predominantly mucus."

"The first of these three corresponding tumor types is the so called Xanthomatous giant cell tumor which we consider as a more or less Xanthomatous (Lipopexic) and an essentially plasmodial form (with giant cells.) Both types may be and are most often associated in the same tumor. In some cases the presence of peculiar spaces further confirm the synovial origin of this tumor type.

"The second type of neoplasm is that containing more or less numerous spaces which are lined with columnar pseudo-epithelial cells. It may contain mucin and shows solid, rather indifferent looking cell strands, through which runs an abundant meshwork of reticulum fibrils. These cells resemble the histiocytes more closely than the common connective



A x 150 Papillary arrangement and spaces lined by columnar cells.



B x 200 Higher power of same.

tissue cell type and may occasionally show phagocytic, lipopexic or sideropexic properties but also may dedifferentiate and become fibroblastic in aspect.

"The third type of tumor is that with a heavy mucicarmine staining mucus between polymorphous and other voluminous histiocytes which are interwoven with a rich reticulum.

"Each of these tumor types may be either benign or malignant. One may finally conceive of the existence of a dedifferentiated type, looking like a common fibro-sarcoma but the truly synovial origin of which may be ascertained only exceptionally."

Summary

The case herein presented falls into the second type. All of the cases of synovial sarcoma which are observed long enough proved to be fatal although the removal of the first tumor seemed most often complete. Recurrences are very frequent and may appear early. Death is generally due to pulmonary metastases from one to five years after the first symptoms appear. The development and evolution of synovial sarcoma is the same in joints, bursae or tendons but is perhaps somewhat more rapid in the bursae. These sarcomata are highly malignant tumors although they seem at first to grow slowly. The prognosis depends to a great extent on the accuracy of the histologic diagnosis. The greater part of the tumor tissue may suggest a rather common sarcoma and only a small portion may show the mucin or reticulum. Once the diagnosis of synovial sarcoma has been established high amputation of the affected extremity is called for. They do not respond to radiation.

We wish to take this opportunity to express our gratefulness and appreciation to Doctor Ralph Kendall, Doctor Perry Hough, Doctor Paul Rosahn and Doctor Burnhardt Zeman for their help in preparation of this report.

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COLOR BLINDNESS TESTS

Thanks to the foresight of U.S. military authorities, new color blindness tests have been compiled by them, thereby making this country independent of Germany and Japan, principal sources of previous color perception tests, it was recently announced by the American Optical Company.

The new tests, approved for use in the armed forces of the United States by the Surgeon-General, will replace as a national standard in this country the Ishihara test, printed in Japan, and the Stilling system, of Germany, both of which are practically impossible to obtain due to the war.

The new compilation, which will be distributed by the optical concern, incorporates the best of the Ishihara and Stilling tests and adds features leading to the detection of those persons who do not wish to pass a color blindness test and also those attempting to hide their color blindness.

The introduction of these new American color tests, comprising 46 printed diagrams and handbook of instructions, it was stated, is particularly timely during the present period of expansion of army, navy, air, rail and highway transportation personnel.

Color blindness, it has been estimated, occurs in from 3 to 4 per cent of men, while only about 0.3 per cent of women are afflicted. The disproportion is accounted for by the fact that the defect is in many cases inherited, remaining latent in the female and becoming manifest in the male offspring. It occurs both as a congenital defect and as an acquired affliction.

For safety on the highway, it was recommended that color blindness tests be made an integral part of a driver's examination. At the present time 9 states require no license to drive, 20 require no visual test, and only one — New York — has a color perception test, recently passed by the New York Legislature. School children should also be tested for color perception because early training may re-educate the color sense in the early stages of a child's development.



State Department of Health

STANLEY H. OSBORN, M.D., Commissioner

Advances With Full-Time Health Leadership Progress Reported in Middletown

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Following the Connecticut River flood in the spring of 1936 with its many demands on local health agencies, the need of a full-time coordinated public health program became apparent to the people of Middletown. The desirability of such a more effective organization of local health resources, the major recommendation following the health survey by the Department of Public Health of the Yale School of Medicine several years previously, had been recognized for some time by the medical profession of Middletown and by others interested in public health. It took a serious emergency to convince the general public that what local physicians long had been urging actually was a necessity.

The Central Medical Society in 1936 took the initiative by being the first local organization to sponsor the movement. This indicates awareness of obligation of the physician to his community since then expressed by Van Etten before the House of Delegates, "The physician should direct local efforts in community health. A community that has no health program is culpably negligent and so are the physicians who permit such service failure." Since almost all other local groups later endorsed the plan, a change in the Middletown city charter made in March, 1937 by the

General Assembly established a strong department of health under a board which was to include at least two physicians. The work of vital statistics was transferred to the new department, and appointment was authorized of a full-time health officer who would be a doctor of medicine qualified not only by clinical experience but by at least one year's training in public health in a recognized institution.

Noteworthy was the attitude of the board of health in selecting the health officer as stated by one of the medical members, "We wanted to get a well qualified man, even though he was not a local resident. We did not ask what his politics were or what his religion was, but only whether or not he had the proper training for the job."

In order to judge the effects of the reorganization of the health department on the community, activities for the calendar years 1937 and 1939 were studied on the basis of standards in the Appraisal Form for Local Health Work of the American Public Health Association. Objective criteria in this manual were arrived at following careful surveys of public health activities in over 200 communities in the United States, including rural areas; and they have been revised in accordance with experience during the past twenty years. This has resulted in the formulation of a fairly effective yardstick by which a city or town may take stock of the adequacy of its health resources. This appraisal measures the combined health program of the community including work by the health department, boards of education, public health nursing association and other official and voluntary health agencies.

APPRAISAL OF HEALTH ACTIVITIES IN MIDDLETOWN

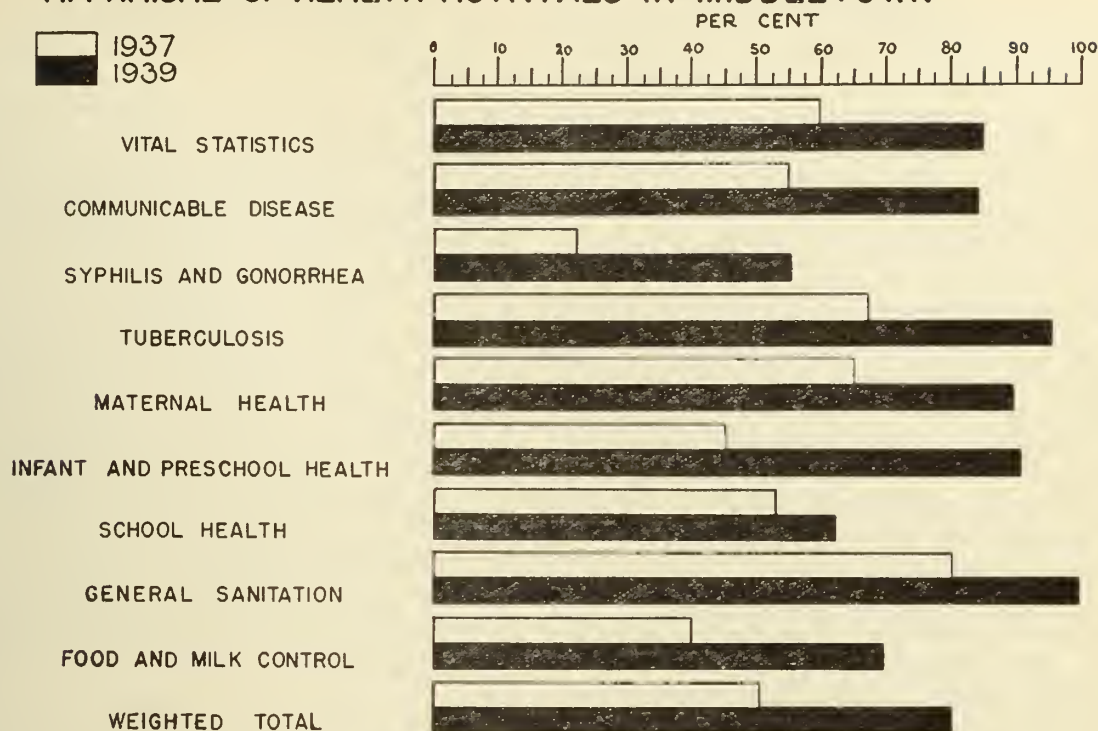


Figure I

The vital statistics service is essential to planning a well rounded community health program. This work was transferred on a state-wide basis to the state department of health in 1878, but locally in many Connecticut cities it still is located in the town clerk's office. In Middletown the change in 1937 enabled better checking of certificates, tabulation, analysis and greater local use of statistics which increased the appraisal score from 60% to 85%.

As may be seen in Figure I, there has been an increase in the total credit on the appraisal from 509 out of 1000 possible points in 1937 to 800 in 1939, with a simultaneous increase in the percentage attainment on each activity. This discloses gains made when Middletown increased its total health investment through its District Nurse Association, boards of education and the board of health from \$26,904 in 1937 to \$34,773 in 1939, or from \$1.04 to \$1.33 per capita.

Acute Communicable Disease Control

An important function of the local health

department is prompt and thorough epidemiological investigation routinely by the health officer of each case of the major communicable diseases, especially diphtheria, dysentery, scarlet fever and typhoid fever. Only through constant vigilance can the source of infection be discovered and susceptible contacts be controlled properly. It is on this point that part-time health officers most often are remiss, not entirely because of lack of training in epidemiology but because of a natural reluctance to make the necessary inquiries into the recent history of a case which is under the care of a fellow practitioner. The full-time health officer also can relieve his colleagues of much embarrassment in making the diagnosis in certain cases of communicable disease, and in Middletown in 1939 the health officer made 23 such consulting calls.

One may compare the effectiveness of communicable disease control in this city under a full-time health officer with that of a neighboring community lacking such protection, since between these two communities there is ample opportunity for interchange of infection. During the period 1937-1938 this neighboring com-

munity had an outbreak of diphtheria giving an incidence of 127 cases per 100,000 population. Contrasted with this in Middletown, owing perhaps to greater promotion of immunization as well as to more careful control over cases, there were only 4 cases during this same period giving an incidence of 16 per 1000,000 population.

Sometime later, in 1938-1939, a widespread outbreak of scarlet fever occurred in the neighboring community at length giving a case rate of 1100 per 100,000 population. In Middletown during this entire period there were 30 cases, all of which were investigated and quarantined promptly, resulting in a case rate of 116 per 100,000 population. These two examples rather forcibly bring out how Middletown already is reaping the benefits of its improved health service.

Syphilis and Gonorrhea

A syphilis clinic was in operation in Middletown prior to organization of the full-time health department. In 1938 the health officer accepted the whole responsibility for the clinic, and gonorrhea cases also were admitted to treatment. The availability of the health officer on a full-time basis for follow-up work resulted in much more complete epidemiologic investigation of cases with home visits to delinquents and to contacts. For example, in 1939, the entire family of each new case of syphilis was persuaded to have a blood test, with the result that all 21 possible family contacts were examined and placed under treatment if found infected. In addition, two extra-familial contacts were examined. Another illustration of the increased activity against venereal disease in Middletown may be seen in the increase in number of blood specimens examined for syphilis from 674 in 1937 to 1688 in 1939.

These case finding and follow-up activities were responsible for the more continuous treatment of cases in 1939 so that the schedule of the Cooperative Clinical Group was followed closely. Of 22 cases under treatment on January 1, 1939, there were 15 on December 31, 1939 who had at least 20 doses of arsenamines and also 20 doses of heavy metals, and the remainder received almost as intensive treatment. The 1937 clinic figures are compared with those of 1939 in Table I.

TABLE I
Activities of Venereal Disease Clinic

	1937	1939
Cases under treatment	19	40
Total visits	311	977
Visits per case	16.4	24.4

Except for those cases which are on the relief rolls, cases of gonorrhea and syphilis are admitted for treatment in the health department clinic only upon referral by the local physicians.

Tuberculosis Control

As in other communicable diseases the initial step in tuberculosis control is securing early diagnosis and reporting of active cases. Although the District Nurse Association had sponsored a diagnostic clinic for some time, activities by various agencies were not well coordinated and physicians were not aware of the need of early reporting and referring of cases for follow-up of contacts. For example, a review of death certificates revealed cases that never had been reported to the health officer.

Under the new setup the clinic is operated as before but all tuberculosis work is integrated in the local health department, where an up-to-date register is kept of the status of all known active or arrested cases of the disease. When physicians report cases, the opportunity is offered of having either the health officer or the public health nurses help to influence family contacts and close associates to come in for examination. That physicians appreciate these services is indicated by the fact that contacts of three-quarters of the new cases reported in 1939 were followed in this way. When necessary the health officer has been in a position to use his legal authority to induce uncooperative sputum-positive cases to accept sanatorium care. A well planned educational program was undertaken to acquaint the people of the community with the importance of early diagnosis, and a tuberculin testing program was started among a class of high school students and among employees of the National Youth Administration.

With all community agencies interested in health joining in the tuberculosis program it is natural that the number of new cases discovered in relation to deaths has increased markedly during the past three years as noted in Table II.

TABLE II.
Tuberculosis Cases and Deaths

	1934-1936	1937-1939
Cases Reported	47	51
Deaths	42	19
Case Fatality Rate	89.4	37.3
Cases Found Per Death	1.1	2.7

Maternity Hygiene

The purpose of the maternal hygiene program is to encourage the women of the community to take full advantage of the facilities available to safeguard the pregnant woman from the hazards of childbearing and to assure normal delivery so that she may continue to carry on her part in family life and in looking after the newborn child. In Middletown organized activity in this field is almost entirely the function of the District Nurse Association, and improvement in the appraisal score has been accomplished by relatively slight readjustments in this program. A small prenatal medical conference is conducted for indigent cases, and public health nurses on request of the family physician render the usual prenatal home nursing services except routine blood pressure readings and the taking of urine specimens. Of the 49 home deliveries in 1939 in Middletown, in 45 cases the attending physician requested and received nursing assistance by this association at the time of delivery.

Infant and Preschool Hygiene

Activities for the promotion of health of the infant and preschool child in Middletown are a cooperative undertaking of the health department and nursing association. Well child conferences are now the responsibility of the board of health which engages a local pediatrician on a fee basis. The District Nurse Association furnishes nursing service at the conferences and makes instructive home visits not only for these cases but also on request to patients of private physicians. The need for stronger medical leadership in this field was evident at the time the full-time health department was organized and the consequent improvement in service may be seen in Table III.

Because local physicians are actively interested in preventive pediatrics, attendance at well child conferences is limited to those in families receiving financial help from the city and to specific cases with a written refer slip from the family doctor.

TABLE III.
Well Child Conferences

	1937	1939
Infants Registered	28	88
Total Visits	51	143
Visits Per Infant	1.8	1.6
Preschool Children Registered	131	354
Total Visits	141	908
Visits Per Child	1.1	2.6

School Hygiene

In Middletown health supervision in the schools is under the individual educational systems, there being a town board of education, a city board of education, and two independent parochial schools. All of the medical, nursing and dental personnel concerned had the best of good will toward one another and to other community health and welfare agencies, but until the advent of the reorganized department of health there was no one individual able to coordinate independent activities in the community at large, in the preschool group, and in the various school groups. This the full-time health officer was able to do, not because of any legal authority but because of his training in child hygiene and health administration and because he had the time to get together with the educational authorities and the medical profession.

One result of this has been to get a movement under way by which responsibility for having the child newly entering school in good physical condition is placed on the parents' shoulders, rather than on the educational authorities. By means of talks to various women's groups and through a series of newspaper articles the public was informed of the importance of continuous child health supervision particularly with a thorough check-up some time prior to entering school, in order to see that the child is protected against diphtheria and smallpox and to have physical defects corrected. In the spring of 1939 both boards of education and the two parochial schools adopted a ruling that every child entering school for the first time in the fall would have to present a physician's certificate that a medical examination had been made. The response this first year was most encouraging, all but a few children at the opening of school having been examined by their family physicians or at the summer roundup the previous June. This encourages having

the examination made with sufficient time before entrance to school to allow for getting the child in proper physical condition. It also helps to have a parent present at the time of examination who can discuss the child's history and personal habits and who can understand more clearly the physician's recommendations.

General Sanitation

The function of sanitation personnel has become less that of law enforcement and more a matter of interpreting regulations, explaining the public health reasons behind them and assisting individuals in complying with the spirit as well as the letter of the law. The sanitary engineer added to the Middletown staff supplements the supervision of the municipal water supply by state engineers, investigates sanitary nuisances reported, has secured considerable sewerage extension and improvement of private sewage disposal facilities, makes a sanitary inspection of all schools at least annually, and has made a survey of industrial plants and public buildings to find and check all cross-connections with the public water supply. In 1939 the Middletown City Council completely revised the building, plumbing and electrical codes in accordance with recommendations of a large committee which included representation from the department of health. There still remains much to be done in the way of improving environmental sanitation in Middletown, but great credit is due for progress already made and for the intelligent program with adequate legal backing that has been put into effect.

Food and Milk Supervision

Effective sanitary supervision can be obtained only by first securing the enlightened cooperation of both proprietors of milk and food handling establishments and of their employed personnel. In Middletown instruction of food handlers in the principles of sanitation and personnel hygiene is done on an individual basis as the routine inspections are made. In 1939 public eating places such as restaurants, soda fountains, and lunch stands received an average of 5.4 inspections per establishment as contrasted with an average of 1.7 inspections in 1937. It is significant that the city has an ordinance requiring thorough disinfection of eating utensils after

each use, and every establishment now has hot water facilities such as to permit immersion of utensils for five minutes in water at 170°F.

Previously to reorganization of the health department, supervision over milk production was left largely to the infrequent visits of state inspectors. In 1939 the number of inspections of farms producing milk to be sold raw was more than doubled, and the kind of inspection made was vastly improved so as to be of distinct value to the farmer as well as to safeguard the consumer. Whereas in 1937 approximately 40% of the raw milk sold had a median bacterial count under 50,000 per cubic centimeter, in 1939 there was 84% of such quality. It is realized that the only safe milk is pasteurized milk and public demand has induced two additional local dealers to install pasteurizing plants. Pasteurized milk sold has increased from 51% in 1937 to 61% in 1939. An average of 14 inspections was made in 1939 to each pasteurizing plant as contrasted with 6 in 1937. The Middletown Board of Health in April, 1938 passed a regulation requiring that caps on all grades of milk cover the pouring lip of the bottle; this went into effect on January 1, 1939.

Popular Health Education

This generation has seen enormous strides in the growth of our knowledge of health and disease, and the general public is fully aware that such scientific discoveries are being made. For many years, interest of the public in its health has been exploited by the promotion of products and "isms" to the tune of such a variety of unpronounceable bodily afflictions as to arouse skepticism in thoughtful minds. People want what is best but they are apt to be misled and confused. In the meantime susceptible children will continue non-immune, and self-medication or worse will take their toll of those whom early diagnosis and proper treatment might save. A large field of work left untilled by many health officers is the making available to the public of information on health which will enable them at least to meet with some degree of discrimination the overwhelming barrage of half truths that are part of modern advertising campaigns, and to remind them of the opportunities for disease prevention and health promotion readily ac-

cessible in their own communities.

This conception of the job of health officer is realized in Middletown as in other progressive Connecticut cities. Being full-time, the health officer always is in a position to meet with a number of groups and committees to make plans and to assist in utilizing health educational resources. He cannot be accused of having an ax to grind when he urges individuals to consult their family physicians promptly for advice when suspicious symptoms appear, for a periodical physical check-up, and for health supervision of the expectant mother, infant, preschool and school child. That his advice is heeded was learned, for example, when a local physician reported that two women with lumps in their breast came in for diagnosis within a few days of the appearance of an article in the local newspaper on carcinoma of the breast.

During 1939 a total of 183 news articles on health appeared in the local paper. There were 7415 pamphlets distributed, and 21 talks were given or nearly 2 each month. The total attendance at these talks was 1738, and in connection with 11 of the talks motion pictures on health were shown. It may be true that perhaps some of the seeds fall on barren ground — the effort is well worth the while when one life has been steered away from the road to quackery and ignorance.

Conclusion

The economy of constructive and efficient health management in Middletown is demonstrated at this early stage by the tremendous improvement in,

1. Planning and coordination
2. Epidemiology and case follow-up
3. Sanitary supervision
4. Community health education.

APPRECIATION

The writer acknowledges his indebtedness for assistance in gathering facts and figures cited herein to the public health workers of Middletown, and particularly to M. L. Palmieri, M.D., M.P.H.; A. Iantosca, S.B.; Clara Baier, and Abbie M. Gilbert, R.N.

REFERENCE

Van Etten, Nathan B. Address to House of Delegates. *J.A.M.A.* 114: 2472; June 22, 1940.

THE GENERAL PRACTITIONER AND HIS HANDBAG

In his recent book *The Patient's Dilemma*, Dr. Hugh Cabot quotes the following statement from Dr. Morris Fishbein: "Obviously, 85 per cent of the diseases for which patients consult doctors are of the type which the general practitioner can handle with the amount of equipment that he can carry in a handbag." Dr. Cabot's comment is "We shall, I think, be on sound ground in asserting that this statement never was true and that it is even less true today . . . I am unaware of any evidence . . . acceptable to any scientific body which would support Dr. Fishbein's allegation."

In an effort to find out which of these views are correct, five Winston-Salem medical men tabulated an average of 200 consecutive cases each. Of the 1,000 patients thus reviewed 848, or 84.8 per cent, had been cared for without any other equipment than the contents of a handbag. A modern doctor's handbag, be it remembered, contains at least a blood pressure apparatus, a stethoscope, a hypodermic syringe, an otoscope, an ophthalmoscope, a transillumination light, a blood counting apparatus, glass slides, a hemoglobin scale, a pleximeter, tongue depressors, Wassermann tubes, culture tubes, and a few other odds and ends.

In tabulating these cases, every patient who had to have a basal metabolism reading, an x-ray examination, an electrocardiogram, an operation or a surgical consultation or who was referred to a clinic for diagnostic survey was included in the referred group even if the doctor had his own basal metabolism apparatus or electrocardiograph. A considerable number of these referred patients, it should be noted, were beyond real help from any medical source; for example, some with arthritis, some with incurable mental disease, and a few who literally enjoyed poor health too much to exchange it for an active existence.

The lowest proportion of patients cared for unaided by an individual doctor was 82 per cent, the highest 89 per cent. The average of 84.8 per cent is certainly close enough to 85 to be acceptable to most scientific bodies as supporting Dr. Fishbein's statement.

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• Editorials •

AMERICA NEEDS A CREDO

Too long have we listened to the siren voice of License disguised as Liberty. Rebellion (against convention) now appears garbed in the classic robes of a recent Renaissance. Our bodies have grown puny and our wits are soft for lack of exercise. Our aesthetic astigmatism is not only condoned but approved by many of our intellectuals. Perhaps they have forgotten that its parents were Mars and Venus or perhaps they don't care. As a nation, our devotion to Bacchus is truly touching — it pays our taxes and fills our jails.

America needs a Credo! What for? Because only by the adoption of a Credo-only by the statement of its creed-only by so crystalizing its deepest convictions and its highest purposes can our nation hope to fuse its massive energies into a gigantic effort for the struggle which even now engages us.

Most of us take America for granted — its freedom of speech and press and religion. We see nothing extraordinary in the liberties of every-day life which we enjoy. We are amazed that any one should wish to curtail them or that millions should more or less willingly sacrifice their own privileges in order-eventually-to enslave us. We like best the government which governs least. We are spoiled children.

We have power! Hidden in our hills are the raw materials which, fashioned in our factories with speed and precision into instruments of defense may well discourage the limitless ambitions of the modern Alexanders. We have power! Hidden in the clever minds of trained technicians are the blue-prints of mass production which, converted to reality will amaze an apparently shock-proof world.

We have Power! But it is unharnessed. It dreams itself to oblivion in the complex seductions of the Jazz Age. It wastes its precious potentialities in futile arguments over the latest football victory. It writes its own Declaration of Independence — not against foreign tyranny but against any attempt to unify its effort (this is called "regimentation") or any plan to deprive it of its toys (here it appeals to the Bill of Rights).

All power comes from within. Mines and factories are inert units until vitalized by the imagination of some human genius. But as Purpose must precede every constructive effort so must Faith embodied in a Credo inspire us to zeal and sacrifice in the task that lies ahead.

In the very nature of things a Credo must be exclusive — one cannot believe everything. This is not the time for broad tolerance and gentle indulgence of the crack-pots, fellow-travelers and the whole tribe of shiftless members of the lunatic fringe. When America has been salvaged we may find time for their comedy — now there is work for warriors to do.

We shall not all go to camp but we all will need to fight — to battle with cynicism and complacency, smugness and stupidity, dissension and defeatism. Some of these enemies are in ourselves, some in others. We must sacrifice pet convictions in the interest of unity and swallow hard truths for the sake of success.

Finally, each one of us must be filled with a deep sense of personal responsibility — a realization that our country is not merely a geographic entity but a dynamic, moving, growing force in the life of the world and that, in a very real sense — “I am an *American*” means “I am *America*.”

D. P. G.

* * * *

SOME OBSERVATIONS ON THE MANAGEMENT OF ACUTE OBSTRUCTION IN THE SMALL INTESTINE

The widespread and increasing employment of gastric and duodenal intubation with constant suction in an attempt to relieve obstruction in the bowel has resulted in brilliant cures in some instances, and great improvement in the condition of other patients as a preliminary to operation. Unfortunately its use in cases of obstruction complicated by strangulation and its prolonged use in unyielding cases of simple mechanical obstruction have resulted in the loss of otherwise salvageable cases. Any obstructed patient who has severe persistent and recurring intestinal colic, general or localized abdominal tenderness, or pelvic tenderness on rectal examination should be treated by operation because the possibility of strangulation is great. In preparation for surgery such cases may be improved by suction

drainage, but some improvement should not delay surgical intervention once the issue is decided. Similarly any apparent improvement following the preoperative morphin medication should not merit reconsideration of the case.

Wide recognition is given to the value of roentgen ray examination of the abdomen in determining the presence, approximate site and degree of an intestinal obstruction. Less well recognized is the value of a repeat examination within a few hours when the diagnosis is in doubt or the condition seems to warrant conservative treatment. A decrease in the number and size of distended loops, with passage of gas on into the large bowel may support a clinical impression of improvement. Increasing distention without change in gas pattern may point to the necessity for surgery. The use of films in the lateral decubitus and erect positions may demonstrate striking fluid levels in bowel and help to determine the approximate point of obstruction.

The results of small irritant enemas (for example, olive oil 200, glycerine 30, turpentine 5) given in series some hours apart may have decisive value. One should not be misled by the passage of a small formed stool or some flatus with or without an enema shortly after the onset of symptoms. Once the distal bowel is cleared out, the true picture of obstipation may develop. Continued return of small fecal particles or colored fluid and flatus suggests that the obstruction is incomplete and perhaps remediable by conservative means.

Patients with constant suction should not be allowed fluid by mouth around the tube. This only aggravates the tendency to loss of chlorides, and usually bases as well. Thirst should be assuaged by local care of the lips and mouth, but chiefly by the treatment of dehydration with adequate parenteral fluid, principally saline. This should be sufficient to counterbalance any loss by the suction route, and to promote the excretion of at least 1,000-1,200 cc. urine daily for the average adult. The specific gravity of the urine and its gross chloride content should be checked. The latter is easily done by testing a specimen with a few drops of silver nitrate solution. Absence of a silver chloride precipitate indicates almost certainly a serious depletion of tissue chloride reserves.

Blood transfusion may be a very valuable supportive measure, even though classical signs of surgical shock are absent.

Enterostomy should be avoided as a treatment for obstruction; when the patient's condition will not justify a search for the primary cause or point of obstruction, an internal intestinal anastomosis between dilated and collapsed loops is to be preferred. Enterostomy may seem to be a more rapid, easier, and better tolerated procedure, but it frequently has lethal sequelae in the form of uncontrolled loss of water, food elements, and electrolytes; hypovitaminosis and abdominal wound digestion are all too prone to appear.

G. E. L.

* * * *

THE CONNECTICUT PLAN FOR HOSPITAL CARE AFTER FOUR YEARS

During the month of February 1941 each member of the Connecticut State Medical Society not already enrolled will be offered membership in the Connecticut Plan For Hospital Care. Conceived in 1937 by lay and medical interests as a strictly local public service for New Haven, it has grown during the past four years to include over 180,000 persons throughout the State and to become the ninth largest non-profit hospital service plan in America.

In New Haven where the plan has been in operation the full four years, over 35% of the entire city and suburban population is now actively enrolled. This in spite of the fact that at the present time approximately 40% of the total population is ineligible because of group enrollment and age restrictions. In communities where the Plan has been adopted more recently, operation figures strongly indicate that the same proportion of enrollment will follow.

There is apparently a very practical reason for this notable acceptance of the Plan by the lay public, its physicians, hospitals and employers. It is the real need for a useful and workable plan which offers the means for the average working person to budget for, and to obtain adequate general hospital care without the humiliating necessity of accepting partial charity or without depleting hard earned savings.

Operating as a non-profit organization under the supervision of the Connecticut State Insurance Department the Plan has no stockholders, or bondholders, employs no commission agents, and as a result all costs of operation approximate only 10% of the payments made by subscribers. During 1940, 72% of all income was paid out in cash for the hospital care of subscribers and the surplus, amounting to \$371,000.00 at the end of the year, was placed in reserve for the benefit of members only.

Respecting the wishes of the Connecticut State Medical Society, the contracts drawn up by the Plan excluded anything that might come under the category of "Medical Services." Free choice of physician by patient is in no way restricted. 31% of those using semi-private accommodations under the Plan have expressed themselves to the effect that, had it not been for their Plan membership, they would have been ward patients and thus would have been unable to engage private physicians. Nearly all discharged cases stated definitely that their Plan membership made it easier for them to pay their physicians' fees.

By slight abuse of the Plan's privileges the medical profession might very easily have forced it into bankruptcy. The profession has evidenced a constant effort to prevent such abuse and by so doing has enabled the working class to obtain adequate hospital and medical care without charity or financial calamity.

Connecticut is fortunate in having the Plan For Hospital Care operating so successfully within its borders. It is fortunate that the originators of the Plan had vision and sound judgment in formulating its guiding principles. The benefits are generous, the restrictions just, as proven during four years of successful operation. Continued operation and understanding on the part of the medical profession of Connecticut will contribute much towards furthering the work of this valuable aid in family economy.

* * * *

ORGANIZING YOUR TOWN FOR HEALTH

Each town, city or borough health officer of Connecticut by law "shall have and exercise all the power for preserving the public health." In contrast to those who fight hog cholera, corn

borers, Dutch elm tree disease or Japanese beetles, he deals in human health and must not only be on guard constantly against the spread of a communicable disease but must use every means within his disposal to promote the health and prolong the life of the men, women and children within his jurisdiction. That task is no mean responsibility. The health officer must keep abreast of the rapid developments in preventive medicine and sanitary science. He must be ahead of the people of his community in his knowledge and understanding of public health, not a weathercock that is blown gently from one new fad to another by dilettante pressure groups. A modern balanced health program is dynamic, not static. It must be well thought out and planned ahead to put first things first and to concentrate on those activities most productive of results, at the same time keeping alert that water (or lives) may not flow over the dike at some neglected and unromantic spot.

While the work of health officer has grown increasingly important, it has become more difficult for the part-time physician to carry on the duties properly as long as he is dependent upon a successful private practice for the chief source of his livelihood. Recent knowledge of bacteriology and epidemiology has indicated the need of a painstaking investigation of each case of the major acute communicable diseases, of early cases of syphilis and of tuberculosis. Regular sanitary inspection of eating places, milk supplies and sewage disposal facilities are necessary; such law enforcement procedures are not likely to win friends for the struggling young practitioner. This routine work as well as the need of constant planning requires someone who makes public health his career, not a side issue.

The report on page 116 of progress made in Middletown under a full-time health officer is of concern to every physician in the state. It points the way toward putting the community health program under the sound leadership of one who will be in a position to help make the lay public aware of the need for regular medical supervision in health as well as in sickness, of the need for early diagnosis and proper treatment of the chronic conditions of adult life as well as the remedial defects of children. There still remain a few cities in Connecticut, some

even larger in population than Middletown, which are attempting to maintain health as a part-time proposition. In the past, towns or cities smaller than Middletown have secured the advantages of full-time service by combining the work of health officer with that of school physician or school medical advisor. However, there is no need for even the smallest towns to lack effective public health service, since Section 929c of the 1935 Supplement to the General Statutes authorizes the formation of sanitary districts composed of groups of cooperating towns, cities or boroughs with a representative local board to draw up the budget, fix policies and to employ a full-time qualified staff. This kind of local health organization is in line with that advocated as part of the platform of the American Medical Association, "The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration."

Physicians all over Connecticut will do well to bring this stimulating report of progress in Middletown to the attention of their local officials and to point out the value of an adequate up-to-date local health organization.

S. H. O.

* * * *

MID-WINTER DINNER OF THE STATE MEDICAL ASSOCIATION

The third annual mid winter dinner of the Connecticut State Medical Society held at the Lawn Club, New Haven, on January 11 was largely attended. Many lady guests were present, one large table being made up entirely of lady guests presided over by Mrs. Francis Blake. There were also present many out-of-town members and guests. Social direction of the dinner was taken over by Doctor Verdi who very gallantly changed gentlemen and ladies at nearby tables so that all had a very jolly party. Doctor Arthur B. Landry, President of the State Medical Society, introduced the speaker of the evening.

Doctor Frank Lahey, president-elect of the American Medical Association, head of the Lahey Clinic, and surgeon of the New England Deaconess Hospital of Boston, gave a very clear resume of the medical economic situation of the United States. He pointed out that

criticism of the American Medical Association should not be resented since it would result eventually in better conditions in medicine. He made a point however, that some criticism is simply rearrangement of prejudices and that much of the criticism of the American Medical Association partakes of this nature. He pointed out the tremendous effort and good results which the American Medical Association has produced but not sufficiently disseminated. Doctor Lahey termed himself a barnyard economist and emphasized certain fundamental economic facts which must not be lost sight of by physicians as well as laymen. He called attention to the fact that there are no substitutes for honesty, hard work, saving as a character builder, obedience, some form of spiritual guidance, and a sense of humor. He stated that medicine is not a commodity which can be bought and sold but is an art and a science, and the essence of the practice of medicine is the direct contact between patient and physician.

Doctor Lahey believes that much of the resistance of physicians to changes in the practice of medicine is due to a fear that the quality of medicine may suffer. The problem of the medically indigent was discussed at some length. The solution of this vast problem Doctor Lahey believes rests with the county medical associations.

It is contemplated that the full text of Doctor Lahey's address will be published in an early issue of the *Journal*.

* * * *

RETURN YOUR DIRECTORY CARDS

To the office of the Medical Society of the State of New York, 292 Madison Avenue, New York City. These cards will be distributed to each of our members as formerly and will replace the data cards previously distributed and compiled by our own State Medical Society. The system of collecting data for the New York, New Jersey and Connecticut Directory has thus been changed. Your attention to this matter will be of great assistance.

DOCTOR EDGAR A. HINES

Another leader has laid down his pen and answered the Last Call. Edgar A. Hines, Secretary of the South Carolina Medical Association for over thirty years and Editor of the Association Journal for almost as long, died on November 27, 1940 at the age of seventy-three, "still active and still busy 'in harness.' " The genial smile, the conscientious manner, and the courteous friendliness of this true Southern gentleman were known far beyond the confines of his native town, Seneca, and of his native state, South Carolina. Faithful to the highest principles of medicine, a student of medicine in its rapid progress through the past fifty years, Edgar Hines' wise counsel and guiding hand will be missed in organized medicine. Fortunate as were those of us who knew him, we mourn his passing, but the example of his loyal spirit shall be ours for years to come.

—☆☆—

BUDGET YOUR BABY

Hospital bills totalling approximately \$25,000,000 will be paid this year by non-profit hospital service plans for the care of subscribers throughout the nation.

A good proportion of that amount will be paid to hospitals in behalf of American mothers who, for payments of three cents a day, have placed the cost of modern hospital maternity services in the family budget.

This non-profit prepayment method of providing protection against the costs of hospital care also may cover the hospital bill for Mother, Dad or the children in the event of unexpected illness or accident.

Sixty such hospital service plans have been established in the United States during the past ten years with the approval of professional groups such as the American Hospital Association, the American Medical Association, the Catholic Hospital Association and the American College of Surgeons.

Today more than five million men, women and children subscribe to these plans and depend upon them for protection against the costs of hospital care.

The Mother

July, 1940

From the Secretary's Office

CREIGHTON BARKER, M.D.

258 Church Street

New Haven

Federal Income Tax

Physicians in practice will use Form 1040 in filing federal income tax returns for the past year regardless of gross income. If income is derived solely from salary and is not more than \$5000.00 Form 1040A should be used. Changes in this year's tax law involve the amount of gross income and the new defense tax. Gross annual income of \$2000.00 or over for married persons and \$800.00 or over for single persons are taxable. The former limits were \$2500.00 and \$1000.00. After all computations have been made the defense tax equals an additional ten per cent of the tax as originally computed. There are many rulings of the Bureau Int. Rev. with respect to allowable deductions for physicians on file in the Secretary's office and queries will be answered within the limits of available information.

January Council Meeting

The Council had its regular monthly meeting in Hartford on January 16th. There were present:

James R. Miller, Chairman, Hartford
 Samuel F. Mullins, Fairfield County
 Edward J. Whalen, Hartford County
 Alfred N. Sweet, Middlesex County
 Thomas P. Murdock, New Haven County
 George H. Gildersleeve, New London County
 Charles T. LaMoure, Tolland County
 Arthur B. Landry, President
 James D. Gold, President-Elect
 Creighton Barker, Secretary

by invitation: Miss Agnes Ohlson, Secretary,
 Board of Examination and Registration
 of Nurses — Miss Marion Douglass, State
 Nurses Association

absent: Charles H. Turkington, Litchfield
 County

Robert C. Paine, Windham County
 Hugh B. Campbell, Treasurer
 Stanley B. Weld, Editor
 George Blumer, A.M.A. Delegate

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The Nursing Practice Act

Representatives of the State Nurses Association and the State Board of Examination and Registration of Nurses met with the Council for a discussion of the application and administration of the Nursing Practice Act. The Council voted that the Society would seek no

amendment to the Nursing Practice Act from the 1941 General Assembly.

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Appointment to Committee on Public Policy and Legislation

The Council appointed Doctor Joseph A. Beauchemin of Middletown to be the member from Middlesex County on the State Committee of Public Policy and Legislation to succeed Doctor George A. Elliott who has removed from the State.

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Representatives to the New England Postgraduate Assembly

The Council appointed Doctors Stanley B. Weld and Louis H. Nahum as representatives of the State Society on the Executive Committee of the New England Postgraduate Assembly.

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Member of State Society to Serve on State Technical Advisory Committee on Problems Related to Food Supply and Nutrition

Dr. John C. Rowley has been designated to serve on this Committee. Other citizens of this State selected to serve are:

Mrs. Marion Evans Dakin, Extension Nutritionist, Chairman

Miss Elizabeth Nickerson, Nutritionist with the State Board of Health

Mrs. Thelma Currier, Special Representative of the Surplus Marketing Administration

Dr. E.A. Perregaux, Economist, formerly in charge of Land Use Program

Mr. Edwin F. Poland, Chairman of the Social Security Board for the State of Connecticut

Dr. Margaret Chaney, Professor of Nutrition at Connecticut College for Women

Miss Edith L. Mason, State Home Demonstration Leader at the University of Connecticut

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The Committee to Study the Medical Examiner System

After submitting the report for the Committee to Study the Medical Examiner System Doctor Stanhope Bayne-Jones, who had been the Committee's Chairman, asked to be relieved from further duty with the Committee and the Council has appointed Doctor Marvin M. Scarborough, Medical Examiner of the City of New Haven, to fill the vacancy caused by Doctor Bayne-Jones' resignation. Doctor Edward H. Kirschbaum, Medical Examiner of the City of Waterbury, has been named Chairman of the Committee.

* * * *

Postgraduate Courses

The postgraduate courses arranged by the Clinical Congress Committee in cooperation with the Yale School of Medicine held their session on January 9th. There are two courses being given, one in Industrial Medicine and one in Nutrition. The registration and attendance at these courses has exceeded the Committee's expectations. There are 58 registered for the course in Industrial Medicine and 61 for the course in Nutrition. Members wishing to register now will be admitted to the remaining sessions which will be held weekly until April.

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Secretary Visits Indiana State Medical Association

The Secretary has recently returned from the Annual Conference of County Presidents and Secretaries in the Indiana State Medical Association held in Indianapolis. The agenda for the meeting included discussions of the problems of health in industry, medical preparedness, current legislation and some pertinent comments on attendance at county meetings. Indiana does things well.

STATE TAXES AND THE SALE OF EYE GLASSES

From time to time there have been discussions of state tax liability for physicians who are engaged in the sale of eye glasses. The Unincorporated Business Tax Law provides that each person engaged in the sale of tangible personal property in this state must pay a tax to the State of Connecticut. The rate of the tax is one dollar per thousand dollars of gross sales. Income derived from businesses of a personal service nature or from professional services is not taxable.

The Attorney General of Connecticut, on January 14, 1938, gave an opinion with reference to the sale of eye glasses by optometrists; "If the optometrist, as an individual, regularly engages in the business of selling eye glasses and spectacles, he is engaged in buying tangible personal property and selling the same for profit. When the optometrist so acts he is a taxpayer as defined by Section 467c of the Supplement to the General Statutes. We are, therefore, of the opinion that when an optometrist sells eye glasses and spectacles in conjunction with his professional services he is liable to the tax on unincorporated businesses.

Although this opinion did not specifically mention physicians, the State Tax Department holds that the subject matter is the same if a physician was engaged in selling glasses in conjunction with his professional service and he would be taxable the same as the optometrist.

This law has not been tested in Connecticut but lately decisions on the subject have been handed down in two other states. In *Kamp v. Johnson*, California, an optometrist sued the state to recover the amount of a tax which the optometrist had paid under pressure contending that he was not subject to the provisions of the California Retail Sales Tax Act because he was engaged in the practice of a profession and the furnishing of eye glasses was purely incidental to the rendering of professional services. An appeal from an adverse judgment was taken to the Supreme Court of California. The higher court affirmed and held that the fact that the plaintiff practiced a profession was immaterial since the plaintiff was engaged in the retail sale of tangible personal property for use by the patient.

In a similar case, *Commonwealth v. Miller*,

Pennsylvania, the defendant sued to collect tax assessed under the Mercantile License Tax Act. It was conceded that the defendant was not liable for taxation with respect to any income derived from his professional services in examining the vision, prescribing glasses and fitting them after they were made, but he was liable to taxation on the retail sale of the glasses that had been made by another. The defendant's contention was ingenious in that an optometrist selling glasses was the same as a dentist selling bridgework or a physician supplying medicine to his patients. The Supreme Court sustained an adverse judgment of the lower court and held that the sale of eye glasses, a tangible chattel, is readily separable from the regular professional services of the optometrist and such sale properly belongs to the occupation of the lens grinder and is not necessary to the practice of optometry. The court disposed of the plaintiff's contention in the case of the dentist and said: "The preparation of the bridgework necessitates considerable professional and scientific skill, labor and design on the part of the dentist. In the case of the physician, it is quite obvious that the furnishing of medicine to the patient is an inherent part of the physician's professional services in the treatment of sickness and disease. But the optometrist in selling glasses is engaged in a business not at all necessary to his profession, and may not claim immunity from the tax merely because he is also engaged in the profession of optometry."



PHYSICIANS RECEIVE GOLD MEDALS

Characterized as "medicated semi-centenarians" by the speaker of the evening, Doctor George Blumer of Yale School of Medicine,

seven physicians of Ansonia, Derby, New Haven and Shelton received gold medals at a testimonial dinner given them at Derby on the evening of January 15. The physicians receiving the medals were Charles T. Baldwin of Derby, 58 years in practice; William Sherman Randall of Shelton, 55 years in practice; Lewis E. Cooper of New Haven, 55 years in practice; Royal W. Pinney of Derby, 53 years in practice; Henry Steudel of Ansonia, 52 years in practice; and Edward K. Parmelee of Ansonia, 52 years in practice.

The medals presented were most interesting. On one side appeared the name of the physician and the caduceus, Mercury's rod, symbolic of the medical profession. On the other side was the inscription: "Presented in recognition of 50 years' medical service to the community, January 15, 1941."

The decorations were in yellow, in keeping with this golden anniversary, and the wife of each guest of honor was remembered with a corsage of yellow souvenir roses, tied with gold ribbon. Doctor Blumer congratulated the guests of honor on having practiced in one of the most extraordinary fifty years in the practice of medicine. He called attention to the many changes that have taken place in the practice of medicine during this half century and expressed the belief that the future of medicine is rich with possibilities.

About 250 physicians, nurses, and their families did honor to the guests by their presence. Doctor S. B. Rentsch acted as toastmaster. The medals were presented by James B. Atwater, former president of Griffin Hospital. Doctor Baldwin responded for his colleagues. The occasion proved to be one of the milestones in medical history in that community.

YOU ASKED FOR IT:

The Professional Equipment Company of New Haven announces that they have a new Taylor Pavaex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

Connecticut Hospital Association

CHRISTMAS OBSERVANCE AT OUR HOSPITALS

Bridgeport Hospital, Bridgeport

Again this year, special Christmas activities were planned for the patients and employees of the Bridgeport Hospital. The trees on the hospital grounds were decorated with colored lights and the trees on the wards were trimmed by the Junior League and the Occupational Therapy Department of the Hospital. The corridors were decorated with lovely wreaths donated by the Fairfield Garden Club.

The Women's Staff of the Children's Ward arranged to have a Christmas tree placed in this department and Santa Claus made his annual visit to the Ward on Tuesday, December 24th, at 4 P.M. All the children received gifts and members of the Girl Scouts sang Christmas carols which were greatly enjoyed by the little patients and their visitors. The Girl Scouts also sang Christmas carols in the adult wards.

At 5:30 on Christmas morning, one hundred students and nurses marched by candlelight through the grounds and the building singing carols. At noon the patients and employees were served a special Christmas dinner. Presents were distributed to the patients.

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Charlotte Hungerford Hospital, Torrington

On December 19th, forty members of the Staff of the Dietary and Housekeeping Departments held a Christmas party in the Auditorium of the Memorial Home. The Committee in charge of arrangements comprised Mrs. Honnour O'Brien, Miss Josephine Hayes, Miss Josephine Lamas and Miss Marguerite Angelone. Music for dancing and carols was furnished by Miss Julia Hamor, accordionist who was accompanied by Miss Mae Scanlon on the piano. During the evening Santa Claus, who bore a strange resemblance to one Felix, appeared and distributed gifts from the grab

bag. Games were played and, following refreshments at 11:30, the meeting adjourned in anticipation of more such enjoyable occasions.

On December 26th, the Administrative Staff met in the Nurses' dining room where refreshments were served. Some Winsted-like stories were indulged in, following which gifts were distributed from the Christmas tree. This party was held in the hospital on this occasion because of the fact that a member of the staff was a patient which prevented the usual custom of holding it in the home of one of the members.

* * * *

Danbury Hospital, Danbury

The hospital celebrated Christmas in a "big way" this year. For the past three years the hospital was too crowded to permit as extensive observance of the holiday. But the new addition has relieved the crowded conditions so the hospital did its best to make Christmas a happy occasion this year.

Even before one entered the hospital, elaborate decorations were to be found. An arch of hemlock had been formed over the front door, lighted at night with blue bulbs. In the main hall was a huge tree appropriately decorated and lighted with multicolored bulbs. There was also a Christmas tree in each of the ten departments. All wards were decorated with wreaths on the windows and greens within the rooms.

The Nurses' Christmas party took place on Friday, December 20th, at which time the Preliminary students entertained with a short play describing Christmas Eve in other lands. The employees had their annual party on December 23rd and Santa Claus visited each patient on this same evening.

Christmas Carols were sung on two different occasions, once by the Camp Fire Girls and again by a quartette from the Methodist Church.

Grace Hospital, New Haven

Christmas was a great event with parties and carols moving smoothly and joyously on schedule. Among other events, the nurses went through the hospital corridors on Christmas Eve singing carols with a beautiful candle-light ceremony. Members of the first, second and third year classes in our Nursing School filled baskets for needy families selected from the patients coming to the Dispensary. A party was held for some of the children in our Clinic at which an article of warm clothing and a toy suited to each child were presented by Santa Claus. Employees in the lower pay bracket, numbering over one hundred, each received a turkey on the day before Christmas.

* * * *

Griffin Hospital, Derby

We have had the usual Christmas Festivities at the hospital with remembrances from various societies and friends. We had carol singing in the hospital wards by the Girl Scouts and members of a church choir; a large tree on the hospital grounds; and Christmas Eve a small boy, a patient in the children's ward, realized his ambition when he was permitted to turn on the lights of the tree!

* * * *

Meriden Hospital, Meriden

While nothing very unusual was planned, we endeavored to make our patients as happy as their enforced stay could be. Each ward had a lighted Christmas tree and on Christmas Eve each patient's tray had a lighted Christmas candle.

On Christmas day, a greeting card and a little frosted tree supplied the decoration. Carols were sung by the local church choirs and a selection of Christmas music, beautifully rendered on the harp by the nine year old daughter of Doctor F. N. Otis, our roentgenologist, was especially enjoyed.

* * * *

New Haven Hospital, New Haven

More than two hundred girls, boys, men and women actively cooperated in making Christmas a festive period at the New Haven Hospital. These were people not on the Staff of the Hospital and all the expense incurred was covered by contributions from these people and their friends.

Thirty-seven Christmas trees were trimmed and set about the wards and waiting rooms, four hundred wreaths and a truck load of hemlock and pine boughs were tied with red, decorated with gold, and hung with peeling gold bells to make the scene a merry one. More than one thousand presents were packaged and given to all ward patients and to those in the Hospital organization.

Groups of caroleers sang on each ward where there were no patients too ill to enjoy it. Puppet shows were given in the children's wards. On Christmas Eve the doctors and nurses of the hospital who could be spared marched in a candle light procession through the entire hospital singing carols. More than 150 of the Hospital organization met on the Hospital grounds and sang carols.

On Christmas morning a real Santa Claus visited the wards to distribute presents. Special greeting cards and favors decorated the trays that carried a real old fashioned Christmas dinner.

"Being in the Hospital on Christmas isn't so bad," said one patient with a leg in traction.

"Believe it or not," said the patient in the next bed, "It's fun."

* * * *

St. Vincent's Hospital, Bridgeport

Many and varied were the preparations for the beautiful Feast of Christmas. On Christmas Eve, the children from Sheridan School came through the Hospital and sang Christmas Carols. They were dressed as Shepherds and Shepherdesses. During the interim in singing these carols, the Gray Ladies of the American Red Cross visited each patient bringing to each a lovely Christmas gift. In the morning at 5 A.M., the Sisters and nurses traversed the hospital corridors singing Christmas Carols. This was followed by a High Mass at 5:30 A.M. sung by the choir of the School of Nursing.

On Christmas morning about ten o'clock, Santa Claus paid his usual visit beginning with the children in the Pediatric Department. Toys had been sent from various concerns and individuals interested in our dear little ones. Santa distributed his presents to each and then went through the hospital visiting all the patients who were eagerly awaiting his visit.

The trays contained all the trimmings that

go with Christmas Day. They were arranged most attractively and elicited many favorable comments. At the end of the day we heard many of our patients say that it was the happiest Christmas they had ever known.

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Windham Community Memorial Hospital, Willimantic

The annual Christmas breakfast of the combined nursing and administrative staffs of the Hospital was held on the morning of the 23rd in the main dining room. This is an annual custom permitting day and night staffs to meet for exchange of gifts and good cheer around a large Christmas tree. This year the pile of packages was so high it required two Santas to distribute the gifts.

Every year each department selects a name from amongst the list ward patients who is considered in greatest need of help and on Christmas Eve a delegation from the nursing staff take a large basket including food, fruit and toys to such homes. This year five families were remembered. Another delegation of nurses visits the Town Home for Aged and distributes small packages of candy and smokes to the inmates. Many of the old people have been hospitalized from time to time and special attention is given to a social visit with these people on this occasion.

Another custom prevailing at the Hospital is having the nearest of kin as dinner guest with the patient. This applies to all semi-private and private cases. The special tray, gay with covers and favors, is served in the room with the patient. This year in one of the solaria a very special party was given for a young patient, who has been hospitalized for many weeks through the Crippled Children's Clinic, when the five members of her family had Christmas dinner with the patient and afterwards exchanged their gifts around a large specially decorated Christmas tree.

A large electric star over ten feet in diameter outlined in colored lights, was illuminated each night from the top sun deck and was visible for many miles. The Hospital had extensive decorations both in the building and on the grounds during the holidays as a result of splendid work on the part of the Junior Auxiliary.

OUR HOSPITALS

Bristol Hospital, Bristol

Mrs. Sanborn reports an average daily census of 93 for the past year and an increase of 26% in the number of patients admitted to the hospital.

She writes: "As usual we are crowded to the doors. Plans are being drawn for a new building which it is expected will be started in the near future."

She also reports a very happy Christmas spirit pervading her institution.

* * * *

Charlotte Hungerford Hospital, Torrington*

The Journal Club of the Charlotte Hungerford Hospital has again taken up its winter activities. On January 2nd, films depicting treatment of the following were shown:

Compound depressed fracture of the skull

Intra-cranial meningioma

Pearly tumor of cerebello-pontile angle

These meetings are open to any physician in the vicinity of Torrington who would be interested in attending.

At the Annual Dinner given by the Board of Governors and Staff of the Charlotte Hungerford Hospital, the deaths on that day were announced of two members of the staff, Doctor Timothy Maher Ryan, age 67, practicing physician in Torrington for 37 years and Doctor Robert Pelton Wadhams, age 61, member of the Medical Faculty of the Bellevue Hospital Medical School. At this dinner also was announced a gift from F. M. Travis, Esq., to the Charlotte Hungerford Auxiliary of \$1000.

It has recently been announced that Frederick L. Braman, Esq., has requested that he be retired from the American Brass Company on March 1, 1941. Mr. Braman as vice-president has been in charge of both the Torrington and Waterbury branches of the Company. Mr. Braman entered the employ of the Coe Brass Company in 1898 and in 1917 was made vice-

*Editor's Note: Every Superintendent should ask Al Buck for a copy of his annual report. We can't reproduce it all here but it is worthy of your attention. The condensed history is most interesting while his method of showing statistics is fascinating. Like all the rest of us, his year shows an increase in the number of patients cared for.

president of the Torrington branch of the American Brass Company, successor to the Coe Brass. He was made vice-president of the Waterbury branch of the Company in 1933. For 17 years Mr. Braman was President of the Board of Governors of the Charlotte Hungerford Hospital during which time the present hospital building was constructed. He succeeded Mr. James Doughty as President of the Corporation in 1922 and was succeeded by Mr. Francis H. Griffiths in 1939. His interest in and devotion to the medical problems of Torrington and vicinity over this long period of time should be of interest throughout the state.

* * * *

Day Kimball Hospital, Putnam

Plans and specifications have been completed for a new wing of fire proof construction consisting of three stories and basement to replace a wing of frame construction. The basement will house out-patient department, laboratories and supply stock room. The first floor will be administrative offices, historian's room and doctors' room. The second floor will provide a six cubicle children's ward and six private rooms which will be large enough for two bed semi-private if necessary. The third floor will have operating suite with two operating rooms and the necessary work rooms for the nurses, sterilizing rooms, etc. It is expected that this addition will be completed in the early Spring.

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Grace Hospital, New Haven

During 1940 many improvements were made at an expenditure of nearly \$25,000. The most important of these was the remodeling of the operating floor thereby securing three additional operating rooms and the furnishing of these rooms with modern tables, lights and other equipment. For one of the orthopedic rooms there was purchased a modern orthopedic table. The Private Pavilion nursery was completely revamped. A baby bath with thermostatic control and mixing tank was purchased. A new MacEachern delivery table was also purchased for this department and new lights placed in the delivery rooms. New nurses' offices were built on each of the floors of the Private Pavilion thereby releasing another private room for patients. New Genito-Urinary rooms were built in the course of the remodeling.

Over \$9,000 was spent for repairs in the heating plant which will reflect a saving of approximately \$4,000 on fuel and water.

A central dish washing room and new equipment has been installed on the floor adjacent to the kitchen and the contract has been let for all of the equipment necessary for a new cafeteria set-up in the nurses' dining rooms.

The year was one of very real progress in this institution.

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Griffin Hospital, Derby

Following is the statistical report of the Griffin Hospital for the year ending May 31, 1940.

Patients admitted.....	2,764
Total number of hospital days.....	27,286
Average number of patients per day....	75
Number of operations.....	1,372
Number of emergency room cases.....	716
Births.....	461
Laboratory examinations.....	26,692
Average daily cost per patient.....	\$5.88
Number radiographs taken.....	3,294

Several changes were made in the hospital during the past year. With some remodeling of the first floor, we were able to add a three-bed room and a two-bed room for the care of patients.

The lobby and the business office have also been greatly improved. The office of the Record Librarian has been moved to the first floor near the hospital entrance and a Nursery and Formula Room were added to Maternity I.

The Veterans Council, formed from the various World War Veterans' Societies in our community, presented the hospital with a Hess Bed Incubator this year. This Council has been very active in raising funds for the hospital and during the past few years the hospital has benefited to the extent of much new equipment including three oxygen tents, a MacEachern Obstetrical Table, a Westinghouse Portable X-Ray Machine, a Foregger Anaesthesia machine, and an emergency Operating Room Spotlight.

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The Hartford Hospital, Hartford

The Hartford Hospital has under construction a temporary building, providing twenty-four private rooms of moderate price. This has been necessitated by the increasing demand which the hospital is unable to meet. The

large increase of population in greater Hartford, due to defense activities, has exaggerated this need. In order to meet the seasonal peak load it is expected that the new unit will be ready for occupancy by February 1st.

In respect to the permanent new building program, plans are progressing steadily and it is anticipated that work on the first unit will be begun in the near future.

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Lawrence and Memorial Associated Hospitals, Inc., New London

In October the Backus Hospital arranged to have Raymond P. Sloan present at an evening meeting at which the executive boards and administrators of the following hospitals were present: Windham Community Memorial Hospital, Willimantic; Westerly Hospital, Westerly, Rhode Island; William W. Backus Hospital, Norwich; and the Lawrence and Memorial Associated Hospitals, New London.

After a buffet supper Mr. Sloan talked to the group, numbering about thirty, on hospital trusteeship. The talk and the discussion following were general in nature. Those present showed a great deal of interest, so much so that it was decided to try continuing such meetings.

Accordingly a second meeting was held at the Lawrence and Memorial Associated Hospitals early in December. At this meeting no attempt was made to have a particular speaker but the meeting was presided over by Dr. Daniel Sullivan, the president, and various matters were discussed with enthusiasm, among them being the question of over-education of nurses, how hospital trustees can organize to be of greater help to their hospitals, etc., etc.

It was decided to attempt a more or less definite organization to be known by some such name as "Eastern Connecticut Hospitals Trustees' Association" and to invite the other three eastern Connecticut hospitals to meet with us, namely: Day Kimball Hospital, Putnam; Rockville City Hospital, Rockville; Johnson Memorial Hospital, Stafford Springs. Dr. Sullivan was elected Chairman of the group and Richard J. Hancock was made Secretary. It was felt that possibly other sections of the state might form similar organizations sometime in the future.

Manchester Memorial Hospital, Manchester

A new wing is being built which it is expected will be completed and ready for occupancy early in May. It is a four story building with new administrative offices, one floor for the Pediatric department, and one floor for Obstetrics which includes a new delivery room, labor rooms and private rooms for maternity patients. The fourth floor will be an entirely private floor. It is also planned to remodel the old building. These additions will increase the capacity from sixty-six to approximately one hundred and ten beds. A new \$45,000 power plant has also been added.

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Meriden Hospital, Meriden

The past year as stated in the report shows that the amount of services rendered to the Community has exceeded that of any previous year in the history of the Hospital. Particularly noticeable was the increase in the number of patients requiring private and semi-private accommodations.

During the year 3,256 patients have been served in the hospital; 217 more than in the previous year, the daily average was 102; the maximum for any one day was 127. During the month of April a daily average of 124 was maintained.

The Operating Revenue was \$174,172.00 as compared with \$149,500.00 last year, representing an increase of \$24,672.00.

The amount of Below Coast and Free Work showed a decrease of \$10,697.87, being partly due to the improved economic conditions and the acceptance of the various Hospital Plans.

The total number of patients admitted under the Hospital Plans for the calendar year of 1940 was 482, representing 10% of the total number of patients treated and 3,989 hospital days.

The Social Service Department is completing its second year of service and has ably demonstrated its value to the Hospital and the Community. A total of 476 patients were referred to this Department for assistance.

The introduction of a Blood and Plasma Bank in November is the newest feature in the Laboratory. The public has responded nobly to the call for volunteers in donating blood for this service.

	1940	1939
Daily average number of patients . . .	31.1	24.5
Number of accidents	338	245
Number of births	161	144
Number of operations	295	290

The year 1940 showed a general increase in all services. At times all private and semi-private rooms were filled and there was a waiting list.

Funds will soon be available from an estate left the hospital. This will allow the building of an addition which will give more private and semi-private rooms and also rooms for isolation of ward pneumonia patients and noisy or very sick patients.

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The Neuropsychiatric Institute of the Hartford Retreat, Hartford

The past year has been one of the most active, if not the most active in the 122 years of existence of the Neuro-Psychiatric Institute of the Hartford Retreat, Connecticut's oldest hospital of any kind.

During the year the personnel has been increased to a new high of 666 persons on the payroll, with a rated capacity of 250 patients. The Nursing Department alone now has a personnel of more than 375 persons and the Faculty of Instructors for Guests, which is an extension of the occupational therapy idea, has reached a new high of more than 60 persons during the year.

Hartford, being one of the greatest centers in the government preparedness program, is suffering a housing and room shortage and the Institute had more than eighty persons, members of the personnel, living off the Campus in rented rooms. As these are increasingly difficult to obtain within easy reach, a new Personnel Building was started before the end of the year with completion called for in sixty working days. This new building will make provision for sixty-one additional members of the personnel formerly living in rented rooms.

The new building will be known as the West Graduate Club, as a supplement to the Graduate Club which was the original residence built a few years ago with a capacity of 250. Besides these two builings, there are five other personnel residences.

An additional cottage, fireproof and air-conditioned is also being completed in sixty days. This will accommodate four patients, each with private bath, and at a cost of ap-

proximately \$25,000. This cottage was given to the institution by a patient's relative.

Closing the old year were the annual dances and New Year's Ball given each year for the personnel. The first took place at Ives Hall at the Institute the evening of December 19th while the formal New Year's Ball, given at the Hartford Club, was attended by more than three hundred members of the personnel of the Institute.

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New Britain General Hospital, New Britain

A new orthopedic table was recently presented to the New Britain Hospital by the New Britain Infantile Paralysis Fund. The hospital has also purchased an instrument washer and sterilizer.

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Norwalk General Hospital, Norwalk

"The December Quarter is invariably the period of minimum occupancy. It is significant, therefore, that the occupancy during that time was 84.4%, which is considered practically full capacity for a community hospital, due to the inevitable segregation of patients and fluctuation in the daily census.

"On the last day of the quarter we were happy to open the additional rooms on the Fifth Floor, recently authorized by the Board and donated to us by the Bedford Fund and members of the Medical and Surgical Staff. For the time being these additional eight beds will take care of the needs of the Maternity Department which shows such a steadily increasing growth.

"During the quarter we were greatly encouraged by the organization of the Hospital Volunteers, a splendid group of about one hundred women who have offered to help the Hospital in various capacities.

"The most encouraging feature of the quarter was the donation to us by the Bedford Fund of facilities to take care of prenatal and post-natal clinics. This addition, costing slightly over \$15,000, will be invaluable.

"As the quarter closes the Woman's Board has become the organizer of a Babies' Alumni Association, which through annual dues of \$1.00 per baby will raise funds to be used for the special care of newborn babies and for the improvement of the nursery facilities."

In his report, all of which could not be used at this time, Mr. Brough stresses the lack of sufficient bed space to care for the ever increasing number of patients seeking hospital care. This is apparently a general condition facing all hospitals and those institutions who can secure funds for additions are greatly to be congratulated. It is a healthy sign for our voluntary hospitals that so many have been able to make some additions to their plants.

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St. Vincent's Hospital, Bridgeport

During the last fiscal year, St. Vincent's Hospital treated 7930 patients with a total of 85,142 patient days. There were 1181 deliveries which indicates the constantly growing demand on the part of the public for hospital maternity service. The laboratory performed 61,083 examinations; the x-ray department 2,226 examinations; the physical therapy department gave 1,240 treatments; while the department of dietetics prepared 48,790 special diets. This latter figure gives some idea as to the part modern diet plays in the care of the sick.

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Waterbury Hospital, Waterbury

Doctor Mason is another superintendent reporting a greater number of patients treated during the last fiscal year than in any other year of the Hospital's history — an increase of 9.07% over 1939 with a daily average of 225 patients.

1651 patients were admitted who were members of some non-profit hospitalization plan and 401 others who were members of various insurance company plans. Doctor Mason estimates that thirty percent of these patients would have had to accept public ward service had they not had membership in one of these plans.

During the year over \$24,000 was spent for permanent improvements, replacements and new equipment.

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ORGANIZATION OF ADVISORY HOSPITAL COMMITTEE FOR THE CONNECTICUT PLAN FOR HOSPITAL CARE

Upon recommendation of the Trustees of

the State Hospital Association and with the approval of the Connecticut Plan for Hospital Care an independent group representing the hospitals affiliated with the Plan have formed an Advisory Committee for the purpose of discussing with Plan officials from time to time various phases of the work which may affect both hospitals and the Plan.

At a meeting of this group it was decided to divide the state into several areas and the following organization was formed:

Chairman — James A. Hamilton
Secretary — Richard J. Hancock

<i>Area</i>	<i>Hospital</i>	<i>Representative</i>
1. New Haven:	Grace Hospital	Sidney G. Davidson
	Hospital of St. Raphael	
	New Haven Hospital	
	Meriden Hospital	
	Milford Hospital	
2. Waterbury	St. Mary's Hospital	Dr. B. Henry Mason
	Waterbury Hospital	
3. Hartford	Hartford Hospital	Dr. Wilmar M. Allen
	Mount Sinai Hospital	
	Manchester Memorial Hospital	
	New Britain General Hospital	
	Bristol Hospital	
	Middlesex Hospital	
4. Western	Charlotte Hungerford Hospital	Albert W. Buck
	Litchfield County Hospital	
	New Milford Hospital	
5. Eastern	William W. Backus Hospital	Richard J. Hancock
	Day Kimball Hospital	
	Windham Community Memorial Hospital	
	Home Memorial Hospital	
	Lawrence and Memorial Associated Hospitals	

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FIRST INTER-AMERICAN IN- STITUTE FOR HOSPITAL ADMINISTRATORS

A new page in hospital history was written last month when the first Inter-American Institute for Hospital Administrators was held in San Juan, Puerto Rico. Ninety-three hospital administrators from ten countries of Central and South America composed the student body of the Institute held at the University of Puerto Rico under the auspices of the American College of Hospital Administrators.

Dr. A. C. Bachmeyer, Director of the University of Chicago Clinics; Dr. M.T. Mac-

Eachern, Associate Director of the American College of Surgeons; Dr. D. C. Smelzer, Director, Graduate Hospital, University of Pennsylvania; and James A. Hamilton, Director, New Haven Hospital (Connecticut) were members of the faculty from the United States.

Not only did this Institute do much to further the art and science of hospital administration, but it made an outstanding contribution to the promotion of understanding and good-will between the Americas.

We should take a great deal of pride in the hospital section of the Journal this month. The very interesting items from so many of our hospitals form excellent reading material and help to more closely establish that bond of fellowship which exists among the superintendents here in Connecticut.

The item from Hancock of the Lawrence Memorial is of special interest and should give us all something to think about and perhaps to plan for.

Your editor appreciates this fine spirit of cooperation and hopes for many more items for the next issue.

Carl Weiler is working desperately to secure additional ads but they come slowly and any help any of our members can give him by suggesting some business concern with whom he can get in touch will be a real service for our association.

The Doctor's Office

Jean Wells, M.D., announces the opening of an office for the practice of medicine limited to Diseases of Infants and Children at 1018 Farmington Avenue, West Hartford.

Our Neighbors

NEW YORK

The Board of Directors of the Metropolitan Life Insurance Company has appointed Dr. George M. Wheatley an assistant medical director. Announcement of the appointment, which is effective January 1, 1941, has been made by Frederick H. Ecker, Chairman of the Board, and Leroy A. Lincoln, president of the Company.

Dr. Wheatley, a graduate of Harvard Medical School, supplemented his training with hospital and clinical service and experience. He has been Principal Pediatrician, in charge of the School Health Service of the New York City Department of Health. He was in active charge of the medical and pediatric phases of the School Health Study Program, carried out by the Metropolitan and other agencies in conjunction with the New York City Departments of Health and Education.

Dr. Wheatley's services with the insurance company primarily will deal with the relationships between the Metropolitan's Welfare Division and medical societies, preventive medical movements and health services, both official and voluntary.

—☆☆—

The individual physician must protect the families in his care, and through them the community, by urging physical examination of domestic employees. Repeated emphasis on the necessity of this should result in the earlier diagnosis of tuberculosis and in the prevention of exposure to infants and children from this source of infection. An annual health certificate declaring freedom from syphilis, onorrhea and tuberculosis should be the requisite for the position of nursemaid. David C. Shar, M. D., *Journal-Lancet*, June 1940.

NEW SERVICE:

The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

(SEE PAGE 2)

Medical Preparedness

COMMITTEE ON MEDICAL PREPAREDNESS

H. Bertram Lambert, M.D. Francis A. Sutherland, M.D. Ralph E. McDonnell, M.D. Donald M. Beckwith, M.D.
 Bridgeport Torrington New Haven Rockville
 Donald B. Wells, M.D. Carl C. Harvey, M.D. Daniel Sullivan, M.D. Edward J. Ottenheimer, M.D.
 Hartford Middletown New London Willimantic
 George M. Smith, M.D., State Chairman, 258 Church Street, New Haven, Conn.

CONNECTICUT PHYSICIANS ON ACTIVE DUTY WITH UNITED STATES ARMY

Names marked with asterisk are members of
The Connecticut State Medical Society.

*Max Alpert, Bridgeport
 *Bernard A. Berman, Waterbury
 Patrick A. Cetrone, Middletown
 Irving G. Gahm, Norwich
 Harry Gillespie, Hartford
 William Reid Haas, New Haven
 Gerald Krosnick, New Haven
 Sydney Luria, Ansonia
 Joseph J. Rozen Pagliaro, Derby
 Alan A. Rosen, New Haven
 *Gershon B. Silver, Hartford
 *C. Seaver Smith, New Haven
 Bob F. Thompson
 John H. Wentworth, New Haven
 Andrew S. Wesoly, New Britain

NATIONAL GUARD

*Maxwell J. Antell, Bridgeport
 Michael C. Anton, Bridgeport
 *John L. Cogland, Hartford
 *John A. DePasquale, Hartford
 Charles T. Desmond, Hartford
 Luther C. Heidger, Stratford
 *Joseph L. Roy, North Grosvenordale

* * * *

On Janury 8 the American Medical Association reported that Connecticut Medical Preparedness questionnaires had not been returned as follows:

Fairfield County	129
Hartford County	64
Litchfield County	3
Middlesex County	6
New Haven County	97
New London County	30
Tolland County	1
Windham County	1

CHANGES IN SELECTIVE SERVICE PERSONNEL

Medical Advisory Board

Hartford District

Pinckney W. Snelling, Hartford has been added as an otolaryngologist

Milton F. Little, Hartford has been added as an ophthalmologist

Board 6A William F. Flanagan, New Britain appointed to succeed Raoul A. Benoit

Board 8B John C. Yavis, New Haven, appointed to succeed Charles E. Sanford

Board 9A Abiahham S. Pinn, New Haven, appointed to succeed C. Seaver Smith

Board 14A Harold A. Johnson, Naugatuck, appointed as additional alternate

Board 14B Robert Salinger, Woodbridge, appointed to succeed Harry W. Stetson, Milford

Board 20B Samuel S. Farago, Pawcatuck, appointed as additional alternate

Board 23B David Garbelnick, Bridgeport, appointed to succeed Charles W. Nichols

Board 24B Albert J. Trimpert, Bethel, appointed as additional alternate

Board 26B Nathan Weinstein, Norwalk, and John Frothingham, New Canaan, appointed as additional alternates

Board 31 Francis J. Cornelio, Winsted, appointed as additional alternate

Board 32 Rupert S. Day, New Milford, appointed as additional alternate

* * * *

LONGEVITY PAY

The annual base pay is increased at the rate of five per cent thereof for each three years of service up to thirty years. Full time will be computed for all periods during which men have held commissions as officers in the Army, Navy, Marine Corps, Coast Guard, Coast and Geodetic Survey and Public Health Service or in the National Guard, Naval Militia and Na-

tional Naval Volunteers or the Naval Reserve Force or Marine Reserve Force when confirmed in grade and qualified for all general service and with full time for all periods during which they have performed active duty under Reserve Commissions and with one-half time for all other periods in which they have held Reserve Commissions.

* * * *

TRAVEL ALLOWANCE

The Order to active duty places the recipient on duty immediately upon receipt and he must report on the date set to the post, camp or station for duty. Travel allowance will be made at the rate of eight cents a mile based on the shortest usual railway route to the station. The trip may be made by automobile but no special delay will be granted on that account.

Transportation for dependents will not be furnished by the government and reserve officers are warned that the housing problem at or within the vicinity of Army stations is likely to be acute so that it will probably be advisable to leave the family at home. In some cases, families of officers are definitely forbidden to follow them to their posts.

* * * *

DOCTOR ROUNTREE MADE MEDICAL CHIEF OF SELECTIVE DRAFT

The President has appointed Doctor Leonard G. Rountree, Philadelphia research scientist, to head the medical division of the national selective service.

The primary objective of this new office which will coordinate and direct the work of the 17,000 physicians throughout the country who have volunteered to examine those called up for military training, is to procure the most suitable men possible. To accomplish this the medical division will help to devise the best way of organizing and eliminating the unfit

during examinations by local draft boards so that the Army will be able to accept practically all men sent to it for induction.

Doctor Rountree was born in London, Ontario, fifty-seven years ago but is now an American citizen. He was formerly a soldier himself, served as an enlisted man during the World War and became a Colonel in the American Expeditionary Forces.

* * * *

RED CROSS-HARVARD HOSPITAL SOON TO BE SHIPPED TO BRITAIN

Administrative staffs of the American Red Cross-Harvard Hospital and the Harvard Public Health Unit which will cooperate in the study and treatment in England of communicable disease under wartime conditions were announced recently in a statement of the American Red Cross and Harvard University which will join forces in the project.

The American Red Cross is constructing in this country a prefabricated 126-bed "siege" hospital which will be set up in February at an un-named site in southwest England. The combined undertaking, comprised of 75 American doctors, Red Cross nurses and laboratory technicians, is scheduled to begin operations upon completion of the hospital. The unit will make an extensive laboratory and field study of communicable diseases under war conditions, reporting their findings to the U.S. Army, Navy and Public Health Service.

Simultaneously the Red Cross and Harvard announced that Dr. John E. Gordon, professor of preventive medicine and epidemiology in the Harvard Medical School, general director of the combined undertaking, is now en route to England. Dr. Gordon will complete final arrangements with the British Ministry of Health and Medical groups. He was accompanied to Britain by Dr. Paul B.

MEDICAL OFFICER'S PAY AND ALLOWANCES

Grade	Annual Base Pay	Monthly Allowances			
		With Dependents	Without Dependents	Subsistence Allowance (30 days)	
				With Dependents	Without Dependents
Colonel.....	\$4,000	\$120.00	\$80.00	\$36.00	\$18.00
Lieut. Colonel.....	3,500	120.00	80.00	54.00	18.00
Major.....	3,000	100.00	60.00	54.00	18.00
Captain.....	2,400	80.00	60.00	36.00	18.00
First Lieutenant.....	2,000	60.00	40.00	36.00	18.00

Beeson of Wooster, Ohio, resident physician of the Peter Bent Brigham Hospital and assistant in medicine at Harvard Medical School, who has been appointed chief physician of the unit.

Preliminary arrangements for the study were made last August when Dr. Gordon went to London with Dr. John R. Mote, of Cambridge, Mass. Dr. Mote remained in London handling details with the Ministry of Health. He will serve as head bacteriologist when the study gets under way.

Bruce D. Smith, representing the Red Cross, will proceed to London later this month to speed erection of the hospital. He will leave with Dr. Gerald F. Houser, Melrose Highlands, Mass., assistant director of the Massachusetts General Hospital, who has been named as superintendent of the hospital.

The Red Cross-Harvard Hospital will consist of 22 buildings of a design developed for modern warfare, Mr. Smith said. They will be constructed of prefabricated sections of five-ply building board sandwiched between fire-resistant sheets. They will be bolted in a structural steel framework and camouflaged to match the surrounding terrain.

At the end of each building there will be a vestibule arrangement to allow doctors and nurses to enter and leave without light escaping. Windows will consist of three parts: heavy-duty plate glass reinforced with wire mesh, screen and blackout shutter.

Ventilation experts have devised a system to circulate fresh air into the rooms during the nightly "lock-up" for blackouts. Light-proof louvres will be installed in each blackout shutter.

Air raid shelters, dug deep into the chalk stata at the site, will be an added safety feature. The entire hospital has been designed to minimize dangers of flying glass and other air raid hazards.

PLANNING FOR A PANDEMIC OF INFLUENZA

Millard Knowlton, M.D., C.P.H.,
Hartford, Conn.

The word "influenza" is derived from an Italian word which means "influence of the stars." Astrologers of medieval times attributed the disease to emanations from stars that reach the earth through the air. If people with whom we associate were all "stars", such an explanation might have merit today.

Etiology. During the past seven years many strains of virus have been recovered from throat washings of patients suffering from influenza, and the accumulated experimental evidence indicating an etiologic relationship between a virus and certain outbreaks of influenza now appears to be overwhelming. However, expert workers have failed to recover the virus from patients in some outbreaks of influenza, and the patients have failed to develop antibodies against the virus recovered from other outbreaks. Thus the disease, or group of diseases, may be classed under two heads; influenza attributed to a virus, and influenza of unknown etiology.

Diagnosis. Laboratory procedures are not practicable as aids in the diagnosis of cases. The recovery and identification of influenza virus from a given throat washing requires not less than three weeks. The neutralization test requires a similar period of time. The complement fixation test for antibodies may be made in 10 to 14 days, but the presence of other antibodies may result in "false positives." Thus, for practical purposes the diagnosis must be based on clinical observation of a large number of cases with symptoms similar to those of a common cold but more severe. The variations in clinical picture may be illustrated by the facetious remark that, "The flu is both affirmative and negative. Sometimes the Eyes have it and sometimes the Nose."

LISTEN TO A FOETAL HEARTBEAT

— through the new "two-channel" Davol Stethoscope Tube. This modern tube will improve your present stethoscope. Latex for long life, heavy wall for durability and to exclude extraneous sounds, with length and weight just right to make it easy to carry and easy to use. One tube; twin channels. No obligation — want to try one? Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2.)

Method of Spread. It is now generally accepted that influenza is spread by direct contact with cases or carriers by droplet infection or by articles freshly soiled with discharges from the nose and throat of infected persons.

Immunization. All strains of influenza virus are not antigenically identical. Ferrets recently recovered from infection by one strain may not be immune to reinfection by another strain. While recent studies suggest the possibility that human antibody response may differ somewhat from that of the ferret, the evidence available is not yet conclusive. Besides no kind of vaccine can even be suggested for immunizing against influenza of unknown etiology. Thus, immunization procedures are not available for use as part of a control program.

Practical Preventive Measures

Preventive measures must be planned primarily on the basis of preventing well people from coming in contact with cases or carriers. As it is not practicable to go out into the primeval forest and live alone during a pandemic of influenza, preventive measures must be considered in relation to actual living conditions and would vary with different groups.

Patients and Contacts. It is not possible to discover cases before they become ill, and while ill, contact with others is limited. From 20 to 30 per cent of well people in contact with cases become carriers, and it is not possible to determine who are carriers of the virus and who are not, even when an outbreak is caused by a virus. Due to recognition of these facts, the sanitary code does not specify restrictions for either influenza patients or contacts.

Institutions. However, it is known from experience that institutions can be quarantined and kept free from influenza during a pandemic outbreak. The quarantine must be rigidly enforced in order to be effective. A single person entering an institution during the quarantine period may carry the disease to the inmates.

Other Groups. On rare occasions a small group in an isolated community might keep away from contact with other people during an outbreak and escape infection. Possibly a group engaged in a vitally important piece of work might be completely isolated until the work is finished. However, the occasion for

such radical procedures would be extremely rare.

General Population. How far should the intermingling of the general population be restricted during a pandemic? If it could be shown that influenza virus might lose some of its virulence by less frequent passage from one person to another, that might justify extreme measures. It is quite apparent that if greatly restricting the intermingling of people would result in slower spread of the disease from one to another so as to extend the outbreak over a longer period with fewer people ill at any one time, such a result would greatly facilitate the furnishing of adequate medical and nursing care. The problem of restricting the intermingling of people would involve consideration of such questions as closing schools, theatres, churches and public meetings of various kinds and having people stay at home as much as possible so as to avoid contact with others. The extent to which such restrictions should be advised would depend in large measure upon the extent and virulence of the outbreak.

Medical and Nursing Care

The proper care of patients would be the real problem occasioned by a pandemic of influenza.

Size of the Problem. Influenza was not made reportable until 1918. Thus, data for evaluating the magnitude of the problem are not available for the many pandemics prior to that time. For the nine-month period, September, 1918 to May, 1919, inclusive, a total of 115,567 cases of influenza were reported in Connecticut. The peak of the outbreak occurred in October when 82,057 cases were reported. No information is available with reference to cases not reported. With the increase in population since 1919, an outbreak of similar magnitude occurring now may be expected to result in approximately 150,000 cases in Connecticut with perhaps 100,000 of them occurring during the peak month of the outbreak.

Service Agencies. While the primary emergency need of a patient is for medical and nursing service by medical and nursing personnel, the many tragedies that occur during such an outbreak require services by other persons and other agencies. In addition to the personal services rendered by private in-

dividuals or agencies, certain kinds of service will need to be rendered by governmental agencies, particularly those concerned with health and welfare.

Emergency Hospitals. During the 1918 outbreak of influenza emergency hospitals were established in 31 Connecticut cities and towns, and buildings of a dozen different types were utilized for this purpose. The magnitude of emergency hospital needs may be visualized by considering present facilities in relation to the possible number of cases should a pandemic occur. According to the latest report on hospital service in the United States by the American Medical Association, 44 non-profit hospitals in Connecticut had 6,728 beds. This is approximately 3.7 beds per 1,000 population. The per cent of occupancy is reported as 71.5. This would mean nearly 2,000 beds available for patients in case of an emergency. The Veterans Hospital, 4 city hospitals and 18 proprietary hospitals are also listed as having a total of nearly 2,000 beds. Assuming a similar percentage of occupancy would give approximately 500 additional beds available for emergency. Assuming an average period of hospitalization of a week to 10 days, 2,500 beds would accommodate not over ten per cent of the possible 100,000 cases occurring in one month in an outbreak similar to that of 1918. The number of emergency hospital beds required would depend upon the proportion of cases hospitalized. On the basis of 100,000 cases in a month's time and other assumptions made in the foregoing, a total of 20,000 to 25,000 emergency beds might be required to hospitalize all of them, or half that number to hospitalize half of them. Also, special ambulance service would be required. The emergency beds needed in any local area would depend upon the size of the population unit and the prevalence of the disease. The figures given herewith are merely suggestive. The actual needs would depend upon actual conditions, rather than speculative possibilities.

Home Care. It is expected that a considerable number of patients, varying in different communities perhaps, would have to be cared for in their homes. This would require the coordination of activities by various cooperating agencies.

Suggested Procedures

As measures taken to meet an emergency would depend primarily upon the magnitude of the problem, it is quite obvious that there must be a definite factual basis for prognosticating a situation calling for unusual activity. An outbreak of relatively small size would not require the special measures indicated for an outbreak of extraordinary magnitude.

State Conference. It may be accepted as axiomatic in order to be consistent with our social system in this section of the country, that local problems would be handled locally and that needs arising from an emergency occasioned by epidemic disease would be met by local agencies. As the organization set-up in larger cities is more complete than in smaller communities, it might be considered advisable in some places to have the problem dealt with on a cooperative basis in a metropolitan area. In order to promote a mutual understanding of the problem from all angles, facilitate co-operation and avoid hasty ill-considered action, it is suggested that if and when an influenza pandemic of similar magnitude to that of 1918 is definitely in the offing, a state conference be assembled to consider policies and procedures. The state agencies represented at this conference should include the health and welfare departments, the medical society, the Red Cross and nursing association. Local representatives should include all local health officers and representatives of county medical societies. Health officers of the larger cities may wish to invite representatives of local welfare departments, medical societies, and nursing organizations. Later, special conferences could be called for special groups if deemed advisable.

Survey of Facilities for Service. This would have to do particularly with possibilities for emergency hospitals in the larger population groups and would be essentially a local problem. It is mentioned here with the idea of suggesting that local representatives planning to attend the state conference might well begin a preliminary survey of local possibilities with reference to emergency hospitals before attending the conference so as to have a basis for discussion at the conference.

Local Committees. Where local problems are to be dealt with by local agencies, it is essential that local committees be formed to meet

emergencies. Such committees would vary with the community. In small towns a committee consisting of the health officer, the first selectman and the public health nurse might deal with the situation adequately. In a large city or a large metropolitan area, the local committee might well include the health officer and representatives from the welfare department, the board of education, the local medical society, the visiting nurse association, the Red Cross Chapter, the large hospitals, the chamber of commerce, the merchants association, the churches, the service clubs, the council of social agencies and other suitable groups. These are merely suggestions. It is realized that special conditions may require variations in the general set-up in different communities.

Local Subcommittees. The problem is so complicated and variable that it would appear desirable to have subcommittees formed to deal with various aspects of the problem in larger communities. Some of these may be listed as follows:

1. *Medical Service.* A subcommittee on medical service might consist of the health officer and representatives of the welfare department and the medical society.

2. *Nursing Service.* The health officer, welfare department, visiting nurse association and private nurses of a community should be represented on a subcommittee on nursing service which may also include a representative of some other agency that might help recruit volunteer nurses for the emergency.

3. *Emergency Hospitals.* Possibly it might facilitate the establishment of emergency hospitals if they could be placed under the management of existing institutions already in operation. An increase in personnel for an existing hospital and the transfer of part of the personnel to an emergency hospital might be expected to obviate some of the difficulties that would naturally be encountered in organizing personnel for an entirely new institution. This and other factors might suggest the advisability of having a committee for each emergency hospital. In any event, the subcommittee on emergency hospitals would be the most important subcommittee to be appointed in any community and special committees of the subcommittee may be appointed to deal with special problems. There should

be representation on these committees from the health department, the welfare department, the hospitals, Red Cross Chapters and other groups particularly interested and in position to be of service.

The Red Cross Disaster Relief Handbook contains detailed specifications for an emergency hospital that are worthy of attention by anyone contemplating the establishment of such an institution.

4. *Ambulance Service.* A special committee, or subcommittee should arrange for ambulance service.

5. *Public Information.* In order to insure that all information given out comes from an authoritative source, it might be desirable for the health officer to act as the subcommittee on public information.

In conclusion, it should be emphasized that the things enumerated herein are merely suggestions. Considerable variation in procedures might be required in making adjustments to local conditions and the magnitude of the problem. Also, similar procedures could be followed in meeting the basic needs for medical and nursing care in other types of disaster.

* * * *

GREAT BRITAIN TO LICENSE U. S. PHYSICIANS

The British Government has made an order under the Emergency Powers Act, passed for the purposes of the war, enabling the General Medical Council to register for the period of the emergency Canadian and United States physicians. They will thus be able to join the Emergency Medical Service with the same privileges as British physicians. Previously Britain has never had medical reciprocity with the United States.

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While the school teacher has not more tuberculosis than the average adult, next to the family she provides the greatest opportunity for close prolonged contact with the school child. To require the teacher to provide a health certificate, including chest films, would serve to remove this reservoir of infection. D. O. N. Lindberg, M.D., *Ill. Med. Jour.*, Oct. 1935.

Legislative Section

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Berkley M. Parmelee, Bridgeport
D. C. Y. Moore, Manchester
Harry B. Hanchett, Torrington
Joseph A. Beauchemin, Middletown
James R. Miller, Hartford

David R. Lyman, Wallingford
Edmund L. Douglass, Groton
Ralph B. Thayer, Somers
George R. Garcin, Danielson
George Blumer, New Haven

Arthur B. Landry, Hartford
Creighton Barker, New Haven

This section will be continued during the session of the 1941 General Assembly. Bills relating to the public health and the practice of medicine will be analyzed in subsequent issues. Information concerning proposed legislation and the schedule of committee hearings are available at the Secretary's office.

EXPRESSING YOUR OPINION

When the General Assembly is considering or passing a law relating to the public health or the practice of medicine, you, as a physician, have a better knowledge than anyone else what the effect of that law will be. Members of the General Assembly do not always know how and why the legislative acts will affect medical practice unless physicians take occasion to tell them. Your opinions are always welcomed by your representatives who, for the most part, are ready to heed their constituents' desires.

The Chamber of Commerce of the United States has issued some suggestions for citizens to follow when communicating with their representatives in the State Legislature or in the Congress of the United States.

DO —

Spell your legislator's name correctly.

State concisely what you think and why — the briefer the better.

Cite specific illustrations, whenever possible, as to effects proposed legislation would have on the practice of medicine and people in your community.

Write on your office stationery.

Sign your name plainly. Type it under the signature.

Send a letter rather than a telegram when time permits.

Take every opportunity to become personally acquainted with your legislators.

DON'T —

Threaten political reprisals.

Write in a captious or belligerent mood.

Remind your legislators of broken promises.

Attempt to speak for anybody but yourself.

Insert newspaper clippings of mimeograph material.

Send a chain letter or post card.

Quote from form letters.

Write only when you want a favor. Letters of commendation are always welcome.

Try to make an errand boy out of your legislator.

Become a chronic letter writer.

* * * *

WHO REPRESENTS YOU?

STATE SENATE

- | | |
|-----------------------------|-------------------------------------|
| 1 Joseph P. Cooney | D. 355 Fairfield Ave., Hartford |
| 2 Frank A. Murphy | D. 122 W. Morningside St., Hartford |
| 3 Leon RisCassi | D. 650 Main St., Hartford |
| 4 William J. Shea | R. Manchester, Conn. |
| 5 C. Fayette Curtiss | R. Southington, Conn. |
| 6 John L. Sullivan | D. 27 Harrison St., New Britain |
| 7 Frank A. Simmons | R. Enfield, Conn. |
| 8 James P. Geelan | D. 145 Henry St., New Haven |
| 9 Samuel H. Malkan | D. 380 Oak St., New Haven |
| 10 Joseph Rourke | D. 65 Spring St., New Haven |
| 11 William L. Egan | D. 400 Lombard St., N. Haven |
| 12 Roy C. Enquist | R. Branford, Conn. |
| 13 Theodore Brysh | D. 318 Broad St., Meriden |
| 14 Clarence F. Baldwin | R. Racebrook Rd., Woodbridge |
| 15 Michael V. Blansfield | D. 1347 W. Main St., Waterbury |
| 16 Edward P. Egan | D. 939 Baldwin St., Waterbury |
| 17 Vincent P. Kiernan | D. Derby, Conn. |
| 18 Joseph A. St. Germain | D. 464 Montauk Ave., New London |
| 19 Joseph B. Downes | D. Norwich, Conn. |
| 20 Alfred Bingham | D. Salem, Conn. |
| 21 Walter P. Barrett | D. 361 Gregory St., Bridgeport |
| 22 Albert L. Coles | D. 272 Vine St., Bridgeport |
| 23 Cornelius Mulvihill, Jr. | D. 84 Ashley St., Bridgeport |

24 Arthur J. Hurley	R. Juniper Ridge, Danbury
25 Herbert E. Baldwin	R. Westport, Conn.
26 George L. Warncke	R. Wilton, Conn.
27 Floyd E. Barbour	R. Greenwich, Conn.
28 Asa R. Scranton	D. South Woodstock, Conn.
29 Pierre J. Laramee	D. 147 Valley St., Willimantic
30 Thomas F. Curtin	D. 30 Mason St., Torrington
31 Frank H. Peet	R. Kent, Conn.
32 Robert O. Judson	R. Main St., Woodbury
33 Finton Thompson	D. 186 Washington St., Middletown
34 John A. Holbrook	R. Westbrook, Conn.
35 Claude A. Mills	R. Rockville, Conn.

Democrats 22

Republicans 13

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35

STATE REPRESENTATIVES

Hartford County

Avon	Fiske H. Ventres, R	Lovely St., Unionville, R. F. D.
Berlin	Lyman E. Hall, R	Kensington
	Stephanie Kamenski, R	Berlin
Bloomfield	Everett C. Wadhams, R	268 Duncaster Rd
Bristol	Joseph P. O'Connell, D.	133 Main St.
	I. Edward Pierce, D.	Lake Ave.
Burlington	Howard B. Hinman, D.	Bristol, (R.F.D. No. 3)
Canton	Harold W. Humphrey, R	Canton Center
East Granby	Richard D. Seymour, R.	R.F.D., Granby
E. Hartford	Frank J. Nolan, D.	25 Adams St.
	Francis W. O'Neil, D.	25 Broad St.
East Windsor	James J. McDermott, R.	Warehouse Point
	H. Wesley Sargent, R.	Broad Brook
Enfield	Francis J. Fahey, R.	Thompsonville
	Michael W. Hullivan, D.	Thompsonville
Farmington	Louis Shapiro, R.	Unionville
	W. W. Hoppin, Jr., R.	Farmington
Glastonbury	Lewis O. Kinne, R.	Glastonbury
	Allen F. Behnke, R.	Glastonbury
Granby	W. Kenneth Avery, R.	Granby
	Raymond E. Case, R.	West Granby
Hartford	Abraham A. Ribicoff, D.	16 Sharon St.
	Ernest T. Raciot, D.	52 Foster St.
Hartland	Frederick C. Raabe, R.	East Hartland
	W. C. Schnetsky, R.	Riverton
Manchester	Charles S. House, R.	18 Scarborough Rd.
	Leland T. Wood, R.	86 Robert Rd.
Marlborough	George Levin, R.	East Hampton, R. D. No. 2
New Britain	Leonard S. Appell, D.	596 W. Main St.
	Nicholas Tomasetti, D.	30 Erwin Place
Newington	James C. Gilbert, R.	North Newington
	Frances B. Redick, R.	North Newington
Plainville	John E. Lamb, R.	67 Broad St.
	Milton M. Koskoff, R.	88 Trumbull Ave.
Rocky Hill	Andrew Twaddle, R.	Rocky Hill
Simsbury	Charles H. Vincent, R.	Simsbury
	Joseph M. Pattison, R.	Simsbury
Southington	John J. Moran, D.	124 Main St.
	J. A. DePaulo, Jr., D.	144 Liberty St.
S. Windsor	Harry F. Farnham, R.	East Windsor Hill

Suffield	Hugh M. Alcorn, Jr., R.	Main St.
	Charles S. Bissell, R.	Main St.
W. Hartford	Harold E. Mitchell, R.	Cedar Ledge Rd.
	Olcott D. Smith, R.	90 Mohawk Drive
Wethersfield	Irving J. Avery, R.	296 Wolcott Hill Rd.
	William E. Hanmer, R.	431 Main St.
Windsor	John Christensen, R.	88 Wilson Ave., Wilson
	J. Ford Ransom, R.	110 Preston St.
Windsr. Locks	Thomas M. Little, D.	Windsor Locks
	35 Republicans	14 Democrats

New Haven County

Ansonia	Edward G. Clancy, D.	46 Vine St.
	H. J. McCormack, D.	6 Alcott St.
Beacon Falls	W. B. Bradley, Sr., R.	Beacon Falls
Bethany	Stanley H. Downs, R.	Westville Sta., R.F.D. No. 2
Branford	John E. Brainerd, R.	Stony Creek
	Irving C. Jacocks, Jr., R.	Branford
Cheshire	Howard F. Baldwin, R	Cheshire
	Frank L. Rice, R.	Cheshire
Derby	Frank Tracy, D.	204 Olivia St.
	Alton Degnan, D.	263 Hawkins St.
East Haven	Charlotte E. Miller, R	63 Bradley Ave.
	Ernest Carpenter, R.	33 Elm St.
Guilford	Gilbert M. Lombard, R.	Guilford
	Eleanor H. Little, R.	Guilford
Hamden	C. Raymond Brock, R.	35 Carlton St.
	Frederick A. Kirk, R.	Shepard Ave.
Madison	Fred. H. Holbrook, R.	Madison
Meriden	William M. Strelau, D.	40 William Ave.
	John Petrucelli, D.	76 Lincoln St.
Middlebury	Charles P. Harper, R.	Middlebury
Milford	Warren A. Field, R.	Milford Point Rd.
	Gordon A. Goldsmith, R	Broad St.
Naugatuck	Thomas L. Jackson, D.	15 Coen St.
	Richard Durkin, Sr., D.	27 Highland Ave.
New Haven	Fred D. Faulkner, D.	262 Crescent St.
	Joseph E. Bove, D.	560 Chapel St.
No. Branford	George H. Augur, R.	Northford
North Haven	Clarence F. Andrews, R	North Haven
	Ralph B. Hemingway, R	North Haven
Orange	William L. Hadden, R.	West Haven
	George E. Clark, R.	Orange
Oxford	Robert Z. Hawkins, R.	R.F.D. No. 2, Southbury
Prospect	Thomas Plumb, R.	Waterbury, R.F.D. No. 2
Seymour	Bernard H. Matthies, R.	28 Pearl St.
	William F. Ablondi, R.	36 George St.
Southbury	Robert C. Mitchell, R.	Southbury
Wallingford	Peter J. Leonard, D.	220 So. Whittlesey Ave.
	Ferdinand Valenti, D.	126 No. Cherry St.
Waterbury	John A. Membrino, D.	268 Cook St.
	Daniel J. Mahaney, D.	1309 Bank St.
Wolcott	Charles D. Gibson, D.	Waterbury, R.D. No. 1
Woodbridge	Clifford I. Stoddard, R.	North Race Brook Rd.
	27 Republicans	15 Democrats

Fairfield County					
Bethel	Herbert B. Wanderer, <i>R</i>	c/o Wilson, Hanna & Wanderer, Danbury	Cornwall	Thomas E. Marston, <i>R</i>	Cornwall
				Miner P. Rogers, <i>R</i>	West Cornwall
			Goshen	Clarence A. Vaill, <i>R</i>	Goshen
Bridgeport	Samuel J. Tedesco, <i>D</i>	156 Rose St.		Samuel J. Breguet, <i>R</i>	West Goshen
	Milton J. Herman, <i>D</i>	825 Capitol Ave.	Harwinton	Henry J. Delay, <i>R</i>	R.D. No. 2 Torrington
Brookfield	John S. Thornhill, <i>R</i>	Brookfield Center		Chauncey E. Hutchings, <i>R</i>	R.D. No. 2, Torrington
Danbury	Joseph J. Gillotti, <i>D</i>	49 Lincoln Ave.			
	Frank A. Doran, <i>D</i>	91 Balmforth Ave.	Kent	Thomas Johnston Boyd, <i>R</i>	South Kent
Darien	Thomas O'Connor, <i>R</i>	Darien	Litchfield	Walter Howe, <i>R</i>	Litchfield
	Virginia Blood, <i>R</i>	Darien		Isabel C. Rylander, <i>R</i>	Litchfield
Easton	W. Hall Coon, <i>R</i>	R.F.D. No. 1	Morris	Sylvanus A. Titus, <i>R</i>	Litchfield, R.F.D.
		Bridgeport	New Hartford	Harry M. Smith, <i>R</i>	New Hartford
Fairfield	Finette B. Nichols, <i>R</i>	Fairfield		Harry B. Goss, <i>R</i>	R.F.D., New Hartford
	Herbert D. Harris, <i>R</i>	5 Moody Ave., Bridgeport	New Milford	Edward A. Ambler, <i>R</i>	Main St.
Greenwich	Milo A. Mitchell, <i>R</i>	Maier Bldg.		Gerald G. Marsh, <i>R</i>	16 Aspetuck Ave.
	Julia B. Mead, <i>R</i>	10 Lenox Drive	Norfolk	Frank C. Buruey, <i>R</i>	Norfolk
Monroe	W. Luckner, Jr., <i>R</i>	Stepney Depot		Philip E. Curtiss, <i>R</i>	Norfolk
New Canaan	Nellie D. Stewart, <i>R</i>	Hoyt St.	N. Canaan	James H. Casey, <i>R</i>	Canaan
	Stanley P. Mead, <i>R</i>	Mead St.	Plymouth	Wilbert N. Austin, <i>D</i>	Plymouth
New Fairfield	Clarissa Nevius, <i>R</i>	R.F.D. No. 3		Stanley Gosinski, <i>D</i>	27 Hickory St., Terryville
		New Fairfield			
Newtown	George M. Stuart, <i>R</i>	Newtown	Roxbury	John F. Pickett, <i>R</i>	Roxbury
	Newton M. Curtis, <i>R</i>	Sandy Hook	Salisbury	Lucille M. Woodward, <i>R</i>	Taconic (Salisb'y)
Norwalk	J. Garvan Cavanagh, <i>D</i>	South Norwalk		W. G. Raynsford, <i>R</i>	Lakeville (Salisb'y)
Redding	Fred A. Judd, <i>R</i>	Redding	Sharon	Alexander Jenkins, <i>R</i>	Sharon
	Bessie Taylor, <i>R</i>	Georgetown		Roland R. Marckres, <i>R</i>	Sharon
Ridgefield	William R. Keeler, <i>R</i>	1 West Wilton Rd.	Thomaston	William G. Johnston, <i>R</i>	Thomaston
	Peter A. McManus, <i>R</i>	8 Fairview Ave.	Torrington	Virginia N. Rossi, <i>D</i>	113 E. Elm St.
Shelton	Frank V. Crofut, <i>D</i>	211 Coram Ave.		Alex Constable, Jr., <i>D</i>	59 So. Main St.
	Patrick J. Walsh, <i>D</i>	45 New St.	Warren	Herbert R. Tanner, <i>R</i>	New Preston
Sherman	Stetson Ward, <i>R</i>	Gaylordsville	Washington	Walfred C. Carlson, <i>R</i>	Washington Depot
Stamford	James H. Miller, <i>D</i>	263 Strawberry Hill		Curtiss T. Woodruff, <i>R</i>	Washington Depot
			Watertown	Joseph R. Neill, <i>R</i>	Watertown
	Robert F. Mulrooney, <i>D</i>	97 William St.		Arthur Russell, <i>R</i>	Oakville
Stratford	Florence A. Abercrombie, <i>R</i>	85 Warwick Ave.	Winchester	Elbert G. Manchester, <i>R</i>	51 Hinsdale Ave.
	Edward S. Birge, <i>R</i>	63 Homestead Ave.			Winsted
				William J. Walker, <i>R</i>	126 Elm St., Winstee
Trumbull	Charles A. Bradley, <i>R</i>	Long Hill	Woodbury	Nils J. Lofmark, <i>R</i>	North Woodbury
	Edward Nothnagle, <i>R</i>	154 Shelton Road, Bridgeport		William P. Bacon, <i>R</i>	Woodbury
Weston	Edward C. James, <i>R</i>	R.F.D. No. 2		38 Republicans	5 Democrats
		(Weston), Westport	Middlesex County		
		(Weston), Westport	Chester	John J. Flournoy, <i>R</i>	Chester
Westport	Anne Hughes Arnold, <i>R</i>	Saugatuck	Clinton	John L. Eliot, Sr., <i>R</i>	Clinton
	C. William Janson, <i>R</i>	Westport	Cromwell	John J. Monnes, <i>D</i>	Washington Rd.
Wilton	George P. VanRiper, <i>R</i>	Norwalk, R.D. No. 1	Durham	Frank J. Francis, <i>R</i>	Main St.
		28 Republicans		Oliver M. Bristol, <i>R</i>	Maiden Lane
		10 Democrats	East Haddam	William E. Nicholas, <i>R</i>	Moodus
				Raymond McMullen, <i>D</i>	Moodus
			E. Hampton	Raymond S. Thatcher, <i>D</i>	East Hampton
				George A. Hovey, <i>R</i>	East Hampton
Barkamsted	John P. Whitehead, <i>R</i>	Pleasant Valley	Essex	Ralph N. Clark, <i>R</i>	Ivoryton
	Alcott Rowley, <i>R</i>	Riverton	Haddam	Belle D. Russell, <i>R</i>	Haddam
Bethlehem	Warren L. Hunt, <i>R</i>	Bethlehem		Charles S. Ingham, <i>R</i>	Haddam
Bridgewater	William M. Curtis, <i>R</i>	New Milford	Killingworth	Bertha G. Heser, <i>D</i>	R.F.D., Deep River
Canaan	Nicholas L. Rogers, <i>D</i>	Falls Village			
Colebrook	Wyllys P. Smith, <i>R</i>	R.F.D. No. 1 Winsted		Peter A. Marcinek, <i>R</i>	R.F.D., Clinton
			Middlefield	Charles N. Burnham, <i>R</i>	Middlefield
	Gus Durst, <i>R</i>	R.F.D. No. 2 Winsted	Middletown	Ellsworth M. Bitgood, <i>D</i>	60 Silver St.
				Frank DelVecchio, <i>D</i>	49 Parl Place

Old Saybrook	James U. Dibble, <i>R.</i>	R.F.D., Saybrook	Ellington	Clyde Cordtsen, <i>R.</i>	Ellington
Portland	William R. Peterson, <i>R.</i>	Bartlett St.	Hebron	Helen E. Sellers, <i>D.</i>	Hebron
Saybrook	Charles E. Strodt, <i>R.</i>	Main St., Deep River	Mansfield	Elton W. Buell, <i>R.</i>	R.F.D., Andover
	Harold J. Stalsburg	So. Main St., Deep River		Edwin O. Smith, <i>R.</i>	Mansfield
Westbrook	John W. Doane, <i>R.</i>	Westbrook	Somers	J. Ward Porter, <i>R.</i>	Star Route, Willimantic
	16 Republicans	6 Democrats		Julia A. Keeney, <i>R.</i>	Somersville
	New London County		Stafford	Oliver C. Pease, <i>R.</i>	Somers
Bozrah	John P. Gribbon, <i>D.</i>	Fitchville		Norman W. Belcher, <i>D.</i>	Staffordville
Colchester	Charles H. Shailor, <i>D.</i>	Colchester, R.F.D. No. 1	Tolland	William J. Delligan, <i>D.</i>	Stafford Springs
	Edward Seger, <i>D.</i>	Colchester, Box 43		Irving P. Campbell, <i>R.</i>	Rockville, R.F.D. No. 2
East Lyme	Fred A. Beckwith, <i>R.</i>	Niantic	Union	Burt C. Hallock, <i>R.</i>	West Willington, R.F.D. No. 1
Franklin	Florence J. Rockwood, <i>R.</i>	North Frnaklin		Ralph A. Bradway, <i>D.</i>	Stafford Springs, R.D. No. 2
Griswold	Napoleon J. Doyon, <i>D.</i>	Glasgo		Frank Kaleta, <i>R.</i>	Stafford Springs, R.D. No. 2
	John Sawicki, <i>D.</i>	Jewett City		Thomas F. Rady, Jr., <i>D.</i>	100 Grove St., Rockville
Groton	Thomas L. Hagerty, <i>R.</i>	Poquonnock Bdg.	Vernon	Ruth Cooley, <i>D.</i>	70 Orchard St., Rockville
	Otto W. Grossman, <i>R.</i>	West Mystic		Frank Joslin, <i>D.</i>	West Willington
Lebanon	Patrick J. Sullivan, <i>D.</i>	Lebanon		Howard W. Pratt, <i>R.</i>	West Willington
	Verson M. Boothby, <i>R.</i>	Chestnut Hill		13 Republicans	9 Democrats
Ledyard	Paul P. Holdridge, <i>D.</i>	Norwich, R.F.D. No. 6	Willington		
Lisbon	Ralph Fitch, <i>D.</i>	R.F.D., No. 4, Norwich			
Lyme	Allen Bartman, <i>R.</i>	Hadlyme		Windham County	
	Charles W. Jewett, <i>R.</i>	Old Lyme, R.F.D. No. 2	Ashford	Leon R. Gardner, <i>D.</i>	Warrenville
Montville	Roland Chagnon, <i>D.</i>	Uncasville		Carl R. Baler, <i>D.</i>	Warrenville
New London	William J. Brady, <i>D.</i>	951 Ocean Ave.	Brooklyn	Fred F. Maynard, <i>D.</i>	Waugan
	Joseph J. O'Connor, <i>D.</i>	16 Pleasant St.	Canterbury	Nelson L. Carpenter, <i>R.</i>	Canterbury
N. Stonington	Frank W. White, <i>R.</i>	R.F.D. No. 1		Richard J. Parkhurst, <i>R.</i>	Canterbury
	J. Bard Bill, <i>R.</i>	No. Stonington	Chaplin	Leon Burdick, <i>R.</i>	Chaplin
Norwich	Alfio Urbanati, <i>D.</i>	Clark Falls	Eastford	Charles H. Buell, <i>R.</i>	Eastford
	Napoleon Pepin, <i>D.</i>	Norwich	Hampton	Asa T. Burdick, <i>R.</i>	R.F.D. No. 2, Hampton
Old Lyme	E. Lea Marsh, Jr., <i>R.</i>	Taftville		T. Emmet Clarie, <i>D.</i>	Danielson
Preston	Georgana C. Miller, <i>R.</i>	Old Lyme	Killingly	Chas. X. Hutchinson, <i>D.</i>	Danielson
		R.F.D. No. Norwich	Plainfield	George F. Dougherty, <i>D.</i>	Plainfield
	William R. Sebastian, <i>R.</i>	R.F.D. No. 3		Eugene W. Bellavance, <i>D.</i>	Moosup
Salem	Joseph L. Nielson, <i>R.</i>	Norwich	Pomfret	Irvin Hattin, <i>R.</i>	Pomfret Center
		R.F.D. No. 3		Carl M. Sharpe, <i>R.</i>	Abington
Sprague	Carl W. Ellison, <i>D.</i>	Colchester	Putnam	William L. St. Onge, <i>D.</i>	Putnam
Stonington	Frank L. Barlow, <i>R.</i>	Baltic		Dorothy J. Bartlett, <i>D.</i>	Putnam
	Samuel Counsell, <i>R.</i>	Stonington	Scotland	Harry P. Chesbro, <i>R.</i>	Hampton, R.F.D.
		207 Mechanic St.	Sterling	Hugh J. French, <i>D.</i>	Sterling
		Westerly, R.I.	Thompson	James J. Canty, <i>D.</i>	Quinebaug
Voluntown	William A. McGuire, <i>D.</i>	Voluntown		Fred A. Munyan, <i>D.</i>	Thompson
Waterford	Thomas B. Woodworth, <i>R.</i>	Quaker Hill	Windham	Margaret C. Hurley, <i>D.</i>	194 North St., Willimantic
	Walter I. Barrett, <i>R.</i>	R.F.D. No. 2		Aime J. Boucher, <i>D.</i>	237 Valley St., Willimantic
	17 Republicans	Waterford			
		15 Democrats	Woodstock	Arthur G. Morse, <i>R.</i>	East Woodstock
	Tolland County			Henry T. Johnson, <i>R.</i>	North Woodstock
Andover	Winthrop White, <i>D.</i>	Andover		14 Democrats	10 Republicans
Bolton	Maud L. Woodruff, <i>R.</i>	R.F.D., Manchester		TOTAL	
Columbia	Horace W. Porter, <i>R.</i>	Columbia		184 Republicans	
Coventry	Ralph V. Reynolds, <i>D.</i>	R.F.D. No. 1		88 Democrats	
		Willimantic		—	
	Eugene W. Latimer, <i>R.</i>	So. Coventry		272 Total Number of Representatives	

COMMITTEES TO WHICH HEALTH AND WELFARE MEASURES MAY BE REFERRED Senate Committees

Appropriations. Chairman, Downes, Norwich; Laramie, Willimantic; Malkan, New Haven; E. P. Egan, Waterbury; Warncke, Wilton.

Finance. Chairman, Blansfield, Waterbury; Curtiss, Southington; Kiernan, Derby; Barrett, Bridgeport; C. Baldwin, Woodbridge.

Judiciary. Chairman, Coles, Bridgeport; Cooney, Hartford; Rourke, New Haven; Murphy, Hartford; Shea, Manchester.

National Defense and Military Affairs. Chairman, Kiernan, Derby; Murphy, Hartford; Mulvihill, Bridgeport; Judson, Woodbury.

Public Health and Safety. Chairman, E. P. Egan, Waterbury; Curtin, Torrington; Bingham, Salem; H. E. Baldwin, Westport.

Public Welfare and Humane Institutions. Chairman, Brysh, Meriden; Rourke, New Haven; St. Germain, New London; Holbrook, Westbrook.

House Committees

Appropriations. Chairman, Sharpe, Pomfret; Christensen, Windsor; Avery, Wethersfield; Stewart (Mrs.), New Canaan; Barlow, Stonington; Curtis, Bridgewater; Field, Milford; Keeney (Mrs.), Somers; Harper, Middlebury; Morse, Woodstock; O'Connor, Darien; Andrews, North Haven; Peterson, Portland; Mahaney, Waterbury; Gillotte, Danbury.

Finance. Chairman, Brock, Hamden; Curtis, Newtown; Eliot, Clinton; Latimer, Coventry; Durst, Colebrook; Rylander (Mrs.), Litchfield; Neill, Watertown; Hanmer, Wethersfield; Hoppin, Farmington; Barrett, Waterford; Neilson, Salem; Farnham, South Windsor; Appell, New Britain; Ellison, Sprague; Brady, New London.

Judiciary. Chairman, Hadden, Orange; Marsh, Old Lyme; Mead, New Canaan; Mitchell, West Hartford; Manchester, Winchester; Mitchell, Greenwich; Fahey, Enfield; Koskoff, Plainville; Wanderer, Bethel; House, Manchester; Jewett, Lyme; Clarie, Killingly; Ribicoff, Hartford; O'Connell, Bristol; Faulkner, New Haven.

National Defense and Military Affairs. Chairman, Clarke, Essex; Walker, Winchester; Niel-

son, Salem; Jacocks, Branford; Ward, Sherman; McDermott, East Windsor; Levin, Marlboro; Stoddard, Woodbridge; Hattin, Pomfret; Pratt, Willington; Marston, Cornwall; Coon, Easton; Rogers, Canaan; Boucher, Windham; Pepin Norwich.

Public Health and Safety. Chairman, Nichols (Miss), Fairfield; Behnke, Glastonbury; Janson, Westport; Carpenter, East Haven; Whitehead, Barkhamsted; Rockwood (Miss), Franklin; Francis, Durham; Mead (Miss), Greenwich; Rogers, Cornwall; Bradley, Beacon Falls; Hunt, Bethlehem; Porter, Mansfield; Munyan, Thompson; Bitgood, Middletown; McMullen, East Haddam.

Public Welfare and Humane Institutions. Chairman, Lamb, Plainville; Abercrombie (Mrs.), Stratford; Hall, Berlin; Russell (Mrs.), Haddam; Hutchings, Harwinton; Barlow, Stonington; Coon, Easton; Woodward (Mrs.), Bolton; Johnson, Woodstock; Little (Miss), Guilford; Curtiss, Norfolk; Boothby, Lebanon; Heser, Killingworth.

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THE NATIONAL CONFERENCE ON MEDICAL SERVICE

The fifteenth annual meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, on Sunday, February 16, 1941. This organization was originally an informal group of representatives from the medical societies of the western and northwestern states who met annually to discuss plans and progress in the field of medical service and was known as the Northwest Regional Conference. Lately eastern states have been asked to participate in the conference and it now embraces a national scope.

The Secretary of The Connecticut State Medical Society has attended these conferences and taken part in their programs. This year the Society will be represented by Doctor Thomas P. Murdock, Doctor Samuel C. Harvey and the Secretary. The Conference on Medical Education and Licensure will take place on Monday and Tuesday following the National Conference on Medical Service.

The program for this year's conference will include discussions of: 1. Voluntary group medical care programs. There will be three speakers who have been instrumental in the

development of definite types of plans and one speaker who, as Chairman of his State Society Committee, will tell "Why We Are Waiting."

2. Medical preparedness. Discussion led by a member of the American Medical Association Committee on Medical Preparedness and two officers of the Medical Department of the United States Army who are responsible for medical services under the Selective Service Law, and a state director of Selective Service and his medical officer. 3. Postgraduate plans of state medical societies. 4. Medical legislative problems. A consideration of legislative problems in federal and state legislatures. 5. Medical care for social security clients. Discussion of proposed plans for medical care for recipients of Old Age Assistance, the blind, and the children.

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AN AGREEMENT BY WAR AND NAVY DEPARTMENTS, FEDERAL SECURITY AGENCY, AND STATE HEALTH DEPARTMENTS

On Measures for Control of the Venereal Diseases in Areas where Armed Forces or National Defense Employees are Concentrated*

It is recognized that the following services should be developed by State and local health and police authorities in cooperation with the Medical Corps of the United States Army, the Bureau of Medicine and Surgery of the United States Navy, the United States Public Health Service, and interested voluntary organizations:

1. Early diagnosis and adequate treatment by the Army and the Navy of enlisted personnel infected with the venereal diseases.

2. Early diagnosis and treatment of the civilian population by the local health department.

3. When authentic information can be obtained as to the probable source of venereal disease infection of military or naval personnel**, the facts will be reported by medical officers of the Army or Navy to the State or local health authorities as may be required.

*Adopted by the Conference of State and Territorial Health Officers, May 7-13, 1940.

**Familial contacts with naval patients will not be reported.

If additional authentic information is available as to extramarital contacts with diseased military or naval personnel during the communicable stage, this should also be reported.

4. All contacts of enlisted men with infected civilians to be reported to the medical officers in charge of the Army and Navy by the local or State health authorities.

5. Recalcitrant infected persons with communicable syphilis or gonorrhea to be forcibly isolated during the period of communicability; in civilian populations, it is the duty of the local health authorities to obtain the assistance of the local police authorities in enforcing such isolation.

6. Decrease as far as possible the opportunities for contacts with infected persons. The local police department is responsible for the repression of commercialized and clandestine prostitution. The local health departments, the State Health Department, the Public Health Service, the Army, and the Navy will cooperate with the local police authorities in repressing prostitution.

7. An aggressive program of education both among enlisted personnel and the civilian population regarding the dangers of the venereal diseases, the methods for preventing these infections and the steps which should be taken if a person suspects that he is infected.

8. The local police and health authorities, the State Department of Health, the Public Health Service, the Army, and the Navy desire the assistance of representatives of the American Social Hygiene Association or affiliated social hygiene societies or other voluntary welfare organizations or groups in developing and stimulating public support for the above measures.

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NURSING INSTITUTE

Nursing Institutes on Prevention and Care of Prematurity were held in Willimantic, Torrington, and New Haven during January. The program consisted of papers and discussion, together with movies, carried on during the afternoon and evening of one day. The Institutes were sponsored by the State Department of Health in affiliation with the Windham Community Hospital, the Charlotte Hungerford Hospital, and the Department of Pediatrics of the Yale School of Medicine.

have been discovered in an institutional outbreak. Infection with various strains of poliomyelitis was reported in cotton rats. Various studies showed that the virus could be recovered routinely from the central nervous tissue of human fatal cases and from experimental animals, and that excepting for tonsils, adenoids, and lymph gland tissue, no other part of the body was shown to harbor the infection.

It was reported that all attempts at producing immunity have thus far met with failure. No chemical has been found which will act on poliomyelitis as sulfanilamide does on certain bacterial infections, yet leads have been discovered and are being further investigated.

Some workers reported that the muscular fibrillation played an important part in the degree of atrophy resulting from nerve destruction; others disagreed. This entire field is opening up a vast amount of research. Instruments have been devised for the more accurate testing of muscle strengths and a table has been designed to evaluate in pounds and ounces the muscle power of the trunk.

Several studies have been completed and others are still being conducted that measure the end results of various forms of surgical and conservative treatment. To obtain the maximum benefits of physiotherapy it has been found that it is necessary to start treatment within six months of the onset; also that ninety seven percent of weakened or paralyzed muscles regain the maximum possible strength within eighteen months of onset of treatment. Rest with physiotherapy in the hospital has been found to have no advantage over similar treatments at home and hospital care over long periods was of decided advantage only when underwater treatments were used. Plaster casts continued over periods of four to six months were disadvantageous, even when frequently reapplied. The value of rest treatment was further emphasized by laboratory studies on infected monkeys. Much work has been done on the study of bony deformity resulting from poliomyelitis but it will take years of observation before conclusions can be drawn.

The Foundation has carried out studies in a few epidemic areas upon the request of and with the consent of the health officers. An

educational program has been conducted so that both professional workers and the public may be better informed of certain aspects of this disease.

At this meeting additional grants were recommended for continuation of existing studies or new investigations in the amount of \$137,350.00 As a result of elections the following chairmen of medical committees were appointed:

Committee on Virus Research — Thomas M. Rivers, M.D., Director, Hospital of Rockefeller Institute for Medical Research.

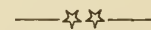
Committee on Research for the prevention and Treatment of After-Effects — Philip Lewin, M.D., Associate Professor of Orthopedic Surgery, Northwestern University Medical School.

Committee on Nutritional Research — James S. McLester, M.D., Professor of Medicine, University of Alabama School of Medicine

Committee on Epidemics and Public Health — Herman N. Bundesen, M.D., Commissioner of Health, Chicago.

Committee on Education — Max M. Peet, M.D., Professor of Surgery, University of Michigan Medical School.

Committee on Medical Publications — Morris Fishbein, M.D., Editor, Journal of American Medical Association.



REHABILITATING THE TUBERCULOUS

"One great problem today in the tuberculosis campaign is the rehabilitation of patients, with training in useful work that will not injure their health and the finding of jobs for them to earn their living when they are cured," according to a statement made by Professor Ira V. Hiscock, President of the Connecticut Tuberculosis Association. Speaking for the Association in New Haven recently, Dr. Hiscock stated that the joint program for rehabilitation of the tuberculous, sponsored by the Association, the State Tuberculosis Commission and the State Department of Education, has aided 281 cases in the state during the past year, and it is proposed to greatly expand the work for the future.

-The -
General Practitioner's
Forum

The treatment of burns seems to be especially vulnerable to argument, and as a general rule each method has a potent champion. That this is so was amply demonstrated during the Chicago meeting of the American College of Surgeons. At the round table discussion on burns, able men presented their versions of the treatment and the arguments that followed were long and heated. However, after the smoke of battle cleared, any impartial observer could readily see that the results were reasonably good whatever the form of treatment. Furthermore, it also could be readily seen that certain procedures advocated, while undoubtedly valuable in the hands of trained 'burn teams', were of little practical use to the average practitioner.

Of the many items discussed several are worthy of decided emphasis. The use of greases and ointments was wholeheartedly condemned as they make the job of instituting proper treatment more difficult. The use of these substances should be limited to mild first degree burns and this fact should be thoroughly publicized, as the average first-aider is the worst offender. There was some discussion on this point. Some of the men felt that they were of some use near the eyes and the natural orifices of the body, however, the consensus of opinion was that the dyes were definitely more useful.

The consensus also agreed that prompt and vigorous debridement was dangerous, even when done under full anesthesia. The first requisite of treatment was to combat shock; when this was controlled, local measures could then be instituted. The management of shock embraced adequate doses of morphine, intravenous fluids and repeated transfusions of whole blood or plasma. Extracts of adrenal cortex were discussed but seemed to be of limited value in this phase of the treatment.

All local treatment started with a thorough

debridement of devitalized tissues. What cannot be removed with a scrubbing brush, green soap and peroxide is cut away. This is followed by a rinse with sterile water. For the production of the eschar, many variants of the original Davidson tannic acid treatment were presented. Of these, one method a combination of Bettman's tannic acid-silver nitrate and Aldrich's three dye seemed to be most practical. The procedure is simple to follow. A fresh 5% solution of tannic acid is sponged over the prepared burned area. This is immediately covered with 10% solution of silver nitrate put on with an applicator. This is limited to the flat body surfaces. Those areas near the eyes, the natural orifices or encircling an extremity are painted with the three dye solution, since the tannic acid-silver nitrate eschar has a constructive action. The three dye solution is made up as follows; equal parts by weight of the dry dyes, brilliant green, gentian violet and acriflavine are well mixed and dissolved in enough water to make a 2% solution. This can be applied either with a swab or spray. The patient is then placed in bed under a lamp frame with the temperature in the tent kept at 85 degrees. As the eschar contracts the edges are painted with dye.

Following the initial treatment, one must guard against delayed shock. This is usually due to blood concentration. Daily hemoglobin readings are important indices of hemoconcentration, and when found to be rising should be treated with transfusions of normal plasma or the newer concentrated plasma.

The late treatment of burns is usually devised to fit the case. This consists chiefly of skin grafting and plastic restorations.

* * * *

The only thing stopping the marketing of a new and effective measles vaccine is a question raised at a staff meeting. The question now being investigated, "Can a child in the process of receiving the immunizing injections be an active carrier of the disease?" Limited tests seem to indicate that the answer will be "No."

T.P.R., M.D.

- NEWS -

from County Associations

Fairfield

The Stamford Medical Society has an excellent plan for getting attendance at the annual meeting as witnessed by the following announcement received over the signatures of Doctors Crane and McMahon of the entertainment committee: "The annual election of officers will be held at the Hubbard Heights Golf Club, Tuesday, January 14. The committee invites you as their guest to a steak dinner. All expenses will be paid from the treasury — Please Post."

On December 21, 1940, Oliver L. Stringfield of Stamford, addressed the Essex County Medical Society at Newark, N.J. Doctor Stringfield's subject, "Problems Associated with Mortality of Premature Infants," was the first in a series of talks aimed to reduce neonatal mortality in New Jersey. The program is under the auspices of the State Child Welfare Committee.

Doctor Bruce S. Weaver has been appointed full-time pathologist at the Stamford Hospital. With the completion of a new addition to the hospital, the pathological laboratory will have new quarters, and Doctor Weaver will have complete charge of the enlarged department.

* * * *

Hartford

Doctors Leo T. Duffy and Francis L. De Pasquale of Hartford are among the doctors leaving for training in Florida.

The following comprise the officers, committee members and chairmen of the Hartford Medical Society for the coming year.

President: Albert R. Keith
 Vice President: R. M. Yergason
 Secretary: Ralph Ogden
 Assistant Secretary: Timothy F. Brewer
 Treasurer: Franklin L. Lawton
 Assistant Treasurer: Clinton D. Deming
 Librarian: Walter Steiner
 Assistant Librarian: Ernest Caulfield

Trustees: Edward J. Whalen, Chairman
 Orin R. Witter
 Howard W. Brayton

Censors: Frank T. Oberg, Chairman
 John F. McDermott
 Bernard Spillane

House Committee:
 Edward A. Deming, Chairman
 George A. Gosselin
 Samuel Donner

Programme Committee:
 Thacher W. Worthen, Chairman
 Max Climan
 Richard E. Dunne
 G. Gardiner Russell
 Walter Weissenborn

Advisory Committee:
 S. H. McPherson, Chairman
 Thacher W. Worthen
 C. Charles Burlingame

Medical Information Bureau:
 H. L. F. Locke, Chairman
 P. F. McPartland
 Burdette J. Buck
 C. Brewster Brainard
 T. H. Denne

* * * *

Litchfield

The Annual meeting of the Torrington Medical Society was held in the Staff Conference Room at the Charlotte Hungerford Hospital on January 8, 1941. The following officers were elected for the ensuing year: President, Floyd A. Weed, Vice-president, William C. Kennedy, Secretary and Treasurer, Michale E. Giobbee. Following a short business meeting, the secretary introduced the speaker of the evening, Lieut. Commander, C. W. Shilling, U. S. Navy Medical Corps. Doctor Shilling was in charge of the medical aspects of the rescue of the survivors of the ill-fated submarine, Squalus. Doctor Shilling presented a model of a diver, described in detail his equipment and method of operation. He also showed pictures of the apparatus used in rescuing the men from the Squalus. He gave a practical demonstration of helium gas in this type of rescue work. Following the meeting, refreshments were served.

On January 7th in the Auditorium of the Charlotte Hungerford Hospital, a program on Prevention and Care of Prematurity was presented. This Institute was one of a series sponsored by the State Department of Health. Others were given at Willimantic and New Haven. 80 Nurses attending the session came from practically every Visiting Nurse district in Western Connecticut.

Doctor Stephen Ignace has resumed his practice after spending three months in post graduate study in surgery at the Polyclinic Hospital in New York City.

* * * *

New London

The New London City Medical Society held its monthly meeting at the Seaside Sanatorium, Dec. 2, 1940. A new plan was inaugurated with this meeting. Instead of having out of town speakers, members of the society will be invited to address the meetings with two objects in mind, (1) To give the members an opportunity to obtain experience addressing medical societies, and (2) to afford the members a chance to discuss interesting cases — cases that were interesting or difficult in diagnosis and cases that presented interest in treatment. At this meeting the speaker was Doctor Edward Gipstein. He presented an interesting case of cranio-pharyngioma with post-mortem findings. Doctor Fred Hartmann gave a brief summary of several similar cases that he had observed at the New Haven Hospital. The meeting was then opened for general discussion.

The society went on record as approving the plan conceived by Doctor Benjamin Pennell, D.V.S., Health Officer of New London, of taking chest x-rays of all age groups in New London and suburbs. Previously the school children were x-rayed in a tuberculosis case finding campaign. This year on February 3rd and February 4th at the old Hook and Ladder Hose house, anyone applying will obtain an x-ray of the chest at the cost of seventy-five cents(\$0.75) if 500 are x-rayed, or one dollar (\$1.00) per person if less than 500 are x-rayed. The x-rays will be taken by Powers and Co., Long Island, N.Y., developed by them and

returned to Uncas-on-the-Thames in Norwich where they will be read by the staff. The diagnosis will be forwarded to the family physician. Letters are being mailed by the health authorities to shops, factories, restaurants, and laundries and newspaper publicity will be given to this campaign in an effort to acquaint as many as possible with the opportunity that is being given the population of this area. On January 9, 1941 a public meeting was addressed by Doctor Alfred Labensky, representing the Lawrence Memorial Hospital, Doctor E. A. Henkle, representing the Home Memorial Hospital, Doctor John O'Brien of the Seaside Sanatorium, Doctor Hugh Campbell of Uncas-on-the-Thames, and physicians from the State Health Department. Publicity in newspapers and letters to merchants and industrialists was used to assure as large attendance as possible.

The monthly scientific meeting of the New London County Medical Association was held at Uncas-on-the-Thames, Norwich, January 2, at 8:30 P.M. A symposium on Pneumonia and Chemotherapy was presented. The speaker of the evening was Doctor Jesse P. G. Bullowa, attending physician at Harlem Hospital, New York City, and associate Professor of Medicine at New York University. The discussion was opened by Doctor Francis Blake, Professor of Medicine at Yale University. There was an unusually good attendance in view of the bad condition of the highways that evening. Doctor Bullowa's presentation and Doctor Blake's discussion were very well received, judging by the many questions Doctor Bullowa answered in an unusually long question period. At the dinner at the Norwich Inn, in honor of the speakers of the evening, there were twenty members present.

Doctor W. H. Weidman, Chief of the x-ray Department., Uncas-on-the-Thames, and Mr. Gene Kieffer, x-ray technician at the same institution, inventor of the laminograph, addressed by invitation a large gathering of Rhode Island x-ray specialists and tuberculosis specialists at Wallum Lake Sanitarium, Wallum Lake, R. I., December 18, 1940. Their subject was — The Laminograph with especial emphasis on its great value in diagnosis of lung and chest conditions.

News from Yale University School of Medicine

During the past several weeks members of the Department of Internal Medicine have been administering preventive inoculations of the new influenza vaccine to several groups of health workers including the professional staff, nurses, and employees of the New Haven Hospital, Grace Hospital, and St. Raphael's Hospital of New Haven, the New Haven City Health Department, students of the Yale Medical School, the Visiting Nurses Association, and the Department of Public Charities. Approximately 2200 doses of the vaccine were given.

The vaccine was supplied by the Rockefeller Foundation. It consists of a saline suspension of Influenza A virus, PR 8 strain, and distemper virus, x strain, which was grown on chick embryo and killed with formaldehyde.

Doctor John F. Fulton, Sterling Professor of Physiology at Yale, has presented to the Yale Medical Library a collection of all books and government documents bearing on military medicine published in England since the beginning of the war, it has been announced. There are some fifty items in all, plus a collection of all the Medical Research Council reports on various phases of industrial medicine. In this latter series there are some seventy titles. These collections are now available to readers in the new Reading Room of the General Medical Library, Sterling Hall of Medicine.

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TREATMENT OF CORONARY ARTERY DISEASE

(Continued from Page 102)

dications. In auricular fibrillation or congestive heart failure complicating myocardial infarction, 6 grains of digitalis leaf should be given daily for two days, then $1\frac{1}{2}$ to $4\frac{1}{2}$ grains daily as long as necessary. An increase in the number of ventricular extrasystoles calls for a reduction in dosage. Digitalis should be beneficial where there is angina of effort with evi-

dence of congestive failure, but is rarely of value and sometimes harmful in uncomplicated angina.

Conclusion

No adequate means exist at the present time of predicting which drug will benefit a given patient with angina pectoris, or indeed whether the patient will respond to any medication in any degree. It is to be remembered that drug therapy is only one factor in the medical management. The regulation of the patient's dietary regime and program of activities, the wise adjustment of emotional factors, the use of moderate doses of alcohol and the correction of anemia, thyrotoxicosis or other organic ailments are of importance.

—☆☆—

OLD NUMBERS OF THE JOURNAL IN DEMAND

In order to furnish complete volumes of *The Journal* to date in reply to many requests which have been received, 50 cents will be paid for copies of any of the following:

Volume 1, Number 3, February 1937

Volume 1, Number 5, August 1937

Volume 2, Number 1, January 1938

Volume 2, Number 3, March 1938

Volume 2, Number 5, May 1938

Volume 2, Number 6, June 1938

Volume 3, Number 2, February 1939

25 cents will be paid for copies of any of the following:

Volume 4, Number 6, June 1940

Volume 4, Number 9, September 1940

Copies should be addressed to The Connecticut State Medical Journal, 54 Church Street, Hartford, Connecticut.

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THE FUTURE OF MEDICINE

Medicine probably is the only field today in which a well educated graduate is sure of making a living and also of having security if he carries disability, life and old age insurance. Except for the crowding in the larger cities, there is no unemployment problem for American medical graduates. Although he will not make a fortune, as large medical incomes may be a thing of the past, the average physician's income at present probably is at its highest level.

Davison, J.A.M.A., Dec. 21, 1940

SPECIAL NOTICES

DATE OF ALUMNI DAY CHANGED AT N. Y. UNIVERSITY COLLEGE OF MEDICINE

The date of the annual Alumni Day at New York University College of Medicine has been changed from the usual Washington's Birthday to March 21 and 22, 1941. At this time, the Alumni Association is celebrating the one-hundredth anniversary of the founding of the medical college.

The program will begin with a dinner for all the alumni and their wives at Hotel Roosevelt on Friday, March twenty-first. On Saturday, the twenty-second, there will be a scientific session at the medical school during the morning and afternoon. The program for this will be published later. There will be a luncheon on the twenty-second in the lounge at the medical school. Dr. Nathan B. Van Etten of the class of 1890, President of the American Medical Association, will be the speaker.

* * * *

SECOND NEW ENGLAND CONFERENCE ON TOMORROW'S CHILDREN

A second New England Conference on Tomorrow's Children will be held July 16, 17 and 18, 1941 in Littauer Center, Harvard University, under the joint auspices of the Harvard Summer School and various cooperating organizations.

The first Conference, held last July, was attended by more than 300 persons. Plans for the new Conference are being formulated by a planning committee on which Carle C. Zimmerman, Professor of Sociology, Harvard University, and Eugene L. Belisle, Executive Director, Massachusetts Mothers' Health Council, will again serve as chairman and secretary, respectively.

* * * *

EXAMINATIONS — AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Cleveland, Ohio, by the entire Board from Wednesday, May 28, to Monday, June 2, 1941, inclusive, prior to the opening of the annual meeting of the American Medical Association in Cleveland, Ohio.

Application for admission to Group A, Part II, examinations must be on file in the Secretary's Office not later than March 1, 1941.

Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *re-examination* in Part II must make written application to the Secretary's Office before April 15, 1941.

The Board requests that all prospective candidates who plan to submit applications in the near future request and use the new application form which has this year been inaugurated by the Board. The Secretary will be glad to furnish these forms upon request, together with information regarding Board requirements. Address Dr. Paul Titus,

Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

* * * *

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held at Boston, Massachusetts May 26th, 27th and 28th, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a type-written double spaced copy sent to the Corresponding Secretary, Dr. W. Blair Mosser, 133 Biddle Street, Kane Pennsylvania not later than April 1st.

The Committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays. Dr. Brien T. King of Seattle, Washington received the Award for the year 1940 in recognition of his essay entitled "A New and Function-Restoring Operation for Bilateral Abductor Cord Paralysis."

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any journal selected by the author.

* * * *

INTERNATIONAL COLLEGE OF SURGEONS TO MEET IN MEXICO CITY

The International College of Surgeons will hold its Fifth International Assembly in Mexico City, August 10-14 1941, in response to the invitation of the Mexican Government. With the assembly will be scientific exhibits of the latest advances in surgery and commercial demonstrations of the newest equipment.

Surgeons in the United States desiring information about the presentation of papers or scientific exhibits are requested to query Dr. Desiderio Roman, Chairman of the Scientific Committee, 250 South 17th Street, Philadelphia. Those seeking travel information are advised to communicate with Dr. Max Thorek, International Executive Secretary, 850 West Irving Park Boulevard, Chicago.

Surgeons from other countries should address the member of the Scientific Committee nearest them. This includes: Dr. Manuel Manzanilla, Mexico City; Dr. Jose Arce, Buenos Aires; Dr. Oswaldo Campos, Rio de Janeiro; Dr. Rudolph Nissen, Istanbul, Turkey; Drs. Raffaele Paolucci and Mario Dogliotti, Italy; Dr. Felix Mandl, Jerusalem; Dr. Y. Seuderling, Helsinki, Finland; Dr. Arnold Jirasek, Prague; and Dr. J. C. McCracken, Shanghai.

• OBITUARIES •



KATE CAMPBELL MEAD, M.D.

1867-1941

On the first day of the New Year, 1941, while characteristically rushing to the aid of a stricken friend, death came suddenly to Doctor Mead in her seventy third year. A full life of absorbing interest ended, as doubtless she might have wished, had the choice been hers, in a last effort to help others.

Kate Campbell Mead was born in Danville, Quebec, Canada, April 6, 1867, and came to this country with her parents in 1870. She was a graduate of the Newburyport, Mass., High School. She received her M. D. Degree from the Women's Medical College of Pennsylvania, Philadelphia, in 1888, and studied at New England Hospital, Boston, John Hopkins University, Baltimore, and hospitals in Europe.

Doctor Mead began medical practice in Middletown in 1893 and continued until 1925

when she went to Europe to do research for a history of women in medicine, a volume which came off the press in 1938. She completed two additional volumes under the same title, "A History of Women in Medicine", which are to be printed post humously. An earlier work, published in 1933, was "American Medical Women Pioneers."

Doctor Mead was prominent in the development of nurses training in Middlesex county, aided in the formation of the Middlesex Hospital Training School for Nurses and founding of the Hospital Aid Society. It was through her efforts that, in 1900, the Middletown District Nurse association was formed. She served as consulting gynecologist at the Middlesex Hospital from 1907 until 1925.

She was a prominent member of the American Medical Association; the Connecticut State Medical Society, of which she served as vice-president in 1913; the Medical Women's National Association of which she was president from 1922 to 1924, the International Association of Medical Women for which she was national secretary and in 1916 president; the American History of Science Society; the Speakers Bureau of the Red Cross, as a lecturer; the American Association of University Women; the Volunteer Medical Corps; the Council of National Defense, in 1917; the League of Women Voters; the Federated Garden Club of Haddam and the Garden Club of America; Middletown Women's Club; Haddam Public Health Association, of which she had been president from 1931 to 1936.

With her distinguished husband, Doctor William E. Mead, professor emeritus of Wesleyan, who is also an author, she travelled widely and frequently in pursuit of her studies and in search of material for her books. Despite her multiple activities she never lost interest in affairs at home, particularly those dealing with public health.

Doctor Mead had a genius for friendship and the thousands of lives touched by her influence will, for long, stand as a monument to her energy, her high intelligence and her willingness to devote her talents to the betterment of mankind.

Jessie W. Fisher, M.D.

• Quarto Notes •

TEXTBOOK ON PRACTICE OF MEDICINE

by

Jonathan Campbell Meakins, M.D., L.L.D.,
Professor of Medicine and Director of the
Department of Medicine, McGill University

1430 pages Third Edition \$10.00
St. Louis C. V. Mosby Co. 1940

In this present day medicine, the status of medical literature is decidedly labile and too voluminous to remain actively useful particularly when one considers that medical periodicals, particularly monthly periodicals become obsolete within five years. It has also been said of textbooks that they may become obsolete almost before they reach the publisher. By re-editing and by re-publishing this present edition, Doctor Meakins has as nearly as possible eliminated from its destructive criticism the foregoing statements.

In twenty one chapters of easily read, easily understood and organized general medical applications, particularly to non-surgical conditions, he has included both the physiological and the physioclinicological approach to almost all these conditions. His scepticism in accepting many of the newer methods of treatment, many of the newer methods of diagnosis is paramount throughout the book, and for this he is to be commended highly. It is, however, unfortunate that when one discusses disease of the body from the medical point of view, on the basis of symptoms or on the basis of etiology, that one should not confine oneself to a more consistent and perhaps more classical formula. An attempt has been made in this review to note both constructively and destructively only those points which appear and seem to be either those of omission or those of too little recognition. Differences of opinion herein noted are considered as those generally accepted.

In discussing diseases of the mouth, we find that the condition known as acute postoperative parotitis has been omitted. The palliative and the curative effect of post-operative radiation of such a disease has also been omitted. Again, when considering the lips, a sign now to be considered very much more important than any other seen, is the cheilitis associated with vitamin B₆ deficiency, now called ariboflavinosis. Vitamin K (synthetic preparation) in disorders of fat metabolism (fat absorpton) seems to be given a secondary status. The reviewer has not noted in the discussion of Acute glandular fever or infectious mononucleosis, the typical mouth lesions with secondary infection of the Vincent's and fusiform organisms. Issue also might be taken with the author on his statement that "acute rheumatic fever is an infection without little doubt." Proof of such statement is still pending. Again, many might contest his notation that erythema nodosum is more frequently found in tuberculosis than in rheumatic

fever. Are leukocyte counts as an index of exacerbation or infection and remission to be considered much more accurate than the blood sedimentating rate? A single line of reference pertaining to the use of the sulfanilamide combinations and compounds in the treatment of meningitis will no doubt invoke no small reverberation. Combined type specific anti-serum and sulphonamide compound therapy in the care of lobar pneumonia seems to have been disregarded with a single comment. Is not the intradermal test of Francis a useful control?

It is fortunate in Chapter VII that Doctor Meakins regards very sceptically the use of heparin in subacute bacterial endocarditis of the non-hemolytic streptococcus type. However, its use in the prevention of postoperative complications and in certain types of thrombophlebitis should perhaps deserve a little bit more consideration. The reviewer finds no reference in the discussion on toxic hepatitis of the recently reviewed cases of toxic hepatitis following severe burns treated with tannic acid. Petressin tannate, to reduce the symptoms of diabetes insipidus, seems to have been neglected. In his discussion of Addison's disease, his scepticism over the use of desoxycorticosterone, seems to be unfounded as evidenced by results reported. It is the opinion of the reviewer, perhaps diametrically opposite the opinion of the author, that it is very definitely of use, both in the form of the synthetic preparation in oil and by pellet implantation procedure. Apparently Doctor Meakins still prefers to use anti-meningococcus serum intrathecally. This perhaps is at variance with the opinion of others who believe that massive doses intravenously are just as efficacious. Tidal drainage in cord injuries and serious atonies of the bladder is given no consideration. Massive doses of vitamin B complex in subacute combined degeneration of the cord again seems to have warranted a very small place in therapy. It is the opinion of the reviewer that the sedimentation rate in rheumatoid arthritis is not always high, and according to the Massachusetts General arthritic studies, it is found that 10% of actively clinical rheumatoid arthritis may have normal sedimentation rates, which brings up the question of the efficacy of the use of the blood sedimentating rate in either following or making the diagnosis of rheumatoid arthritis. A therapeutic test of salicylates in acute rheumatic fever is not mentioned, which in turn raises the question of the use of therapeutic tests and provocative tests in helping to establish a diagnosis which Doctor Meakins, the clinician that he is, believes are not useful and are never useful. The upset in calcium metabolism to which he refers in renal ricket's is not merely an upset in calcium metabolism, but is probably now thought to be due to a definite acidosis in the kidney itself. In the treatment of primary syphilis no mention is made of the continuous five day intravenous arsenicals. Tetanus toxide and the nasal instillation of tetanus toxide is not considered for prophylaxis nor is it considered for active treatment. In the active stages it is now accepted that massive doses given every other day of anti-tetanus antitoxin is the accepted treatment. Picrotoxin is not included in the usual list of stimulants efficacious in the treatment of barbiturate poisoning. Boeck's sarcoid is mentioned as at times showing an x-ray lung lesion which simulates miliary tuberculosis, but periarteritis nodosa has no such mention.

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These forgoing statement, corrective suggestions, and omission inclusions should be considered in no way detrimental to the appreciation of such a stupendous piece of work as Doctor Meakins has carried out in publishing and re-editing so soon this new textbook. It is humanly impossible for any one man to keep abreast with all the events in modern day medicine. The book is an excellent reference book and should prove to be worthy addition to any professional man's library.

W. H. Lowell, Jr.

* * * *

OBSTETRICS IN GENERAL PRACTICE by

J. P. Greenhill, B.S., M.D., F.A.C.S.

Professor of Obstetrics and Gynecology,
Loyola University Medical School

448 pages	200 illustrations	\$3.50
Chicago	Year Book Publishers	1940

Like its companion book "Office Gynecology," this is a very valuable manual for the general practitioner. It contains the elementary facts in obstetrics with a clear presentation of the best accepted methods of treatment. As the author so succinctly states in his preface, "the material in this book must be well known by every physician who delivers babies. Those who possess this knowledge will have little use for this book. All other physicians who practice obstetrics must thoroughly acquaint themselves with this information through this or some other book on obstetrics, else they will not be safe practitioners of medicine. The latter physicians are the ones who are responsible for the present high maternal and fetal mortality and morbidity."

There are several details of treatment presented in this volume worthy of passing notice as, for example, a modification of Irving's treatment of hyperemesis gravidarum. The use of the Willett traction forceps in placenta praevia is not generally accepted and it is difficult to agree with the author's attitude toward caesarian section in abruptio placentae, a procedure which in safe hands has produced excellent results. The use of castor oil and quinine has long since lost its popularity in many hospitals and with the judicious use of pituitrin in small doses together with artificial rupture of the membranes seems hardly necessary. Doctor Greenhill's illustration of the correct way of removing placental remains should be adopted by all who carry out this procedure.

The volume fills very admirably the niche for which it was intended, in general practice, but careful perusal of its contents should benefit any and all who practice obstetrics.

* * * *

THE SUBJECTION OF WOMAN AND THE TRADITIONS OF MEN

by

Maude Glasgow, M.D., D.P.H.

Author of "Life and Law," "The Scotch-Irish
in Northern Ireland and in the American
Colonies"

341 pages	\$3.00
New York City	1940
Doctor Maude Glasgow, of New York City, has	

recently found it expedient to publish a history of woman down the ages in order to prove man's deliberate campaign to lift himself on the shoulders of the submissive but "weaker sex." I am reminded of a very pretty waitress in a London boarding house who, being twenty years of age, announced savagely that she was a "man-hater." Two years later she was happily married and the mother of a beautiful baby. One's hatred or admiration depends on circumstances. It is all in the point of view.

Doctor Glasgow's book has 341 pages without any documentation or bibliography or index. The book bristles with barbed wire and electric points to prove man's usurpation of nine-tenths of the virtues of woman, thereby calling attention to his own superiority. She fairly shrieks at women to cast off their chains at once. She says in the Preface, "For more than six thousand years the history of woman has been one of hopeless sadness. She moved only to the clank of chains, and her vain desire for better and higher things could not find expression, for woman was by force of circumstances inarticulate." She urges women to bind themselves into a solid phalanx as men have bound themselves, and assert themselves, legally, medically and professionally. This brings a smile to the lips of a "joiner" who can not find the name of Doctor Glasgow even among the list of members of the American Medical Women's Association! It is amusing and somewhat disturbing, logically.

An immense number of facts have been drawn together by the author to prove her points, but her extreme partianship makes her less convincing than if she were less cruel to men and more understanding of women's psychology and genes. In contradistinction to John Stuart Mill and his philosophy on the *Subjection of Woman*, and Mary R. Beard, in her work *On Understanding Women*, we find Doctor Glasgow much less convincing than those pacific individuals. She implores women to defend themselves from predatory man, and push men back into a corner and hedge them in, soften their nature; and thus distribute authority such as was once held by the matriarchs. This is what a certain cowboy of the plains said was happening to men under prohibition; said he, "men are becoming so soft that they must take their milk from a bottle with a nipple, and wear a bib!"

John Stuart Mill's Essay on the *Subjection of Women* was published in 1869. It was re-edited and published in 1924 and shows in a gentle but convincing manner that the objections given by men as to the acknowledging the value of women are rooted in mere feelings and usage, based on man's superior physical strength. — primitive slavery sanctioned by society, and lasting on. "Such absolute monarchy," said he, "is based on the undisguised love of gain and power." He closes his book with the suggestion that the subjection of one half of the human family by the other half leaves the species less rich in all that makes life valuable to the individual human being. — in fact his is a plea for universal suffrage, while Doctor Glasgow's plan is for a *Woman's Party*.

However, this book of Doctor Glasgow's should be bought and read by all who enjoy an argument. It should ultimately stand on a five-foot shelf along with *Beard and Mill*, Carrie Chapman Catt and Lucy Stone

There's no fee for this advice

In cases of real thirst,
nothing is more welcome to
a welcome guest than a high-
ball made with smooth, mel-
low Johnnie Walker . . .



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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph. Gon. & Ven. Dis.*, 23, 201 (March) 1939.

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K. C. H. Mead

— ☆ ☆ —

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Table of Contents :: March 1941

ORIGINAL PAPERS

RELATION OF THE DOCTOR TO THE HOSPITAL	JAMES RAGLAN MILLER, M.D., Hartford	165
REMARKS ON EFFICIENT TRACTION	H. W. WELLINGTON, M.D., New London	170
SOME ECONOMIC PROBLEMS BY A NON-PROFESSING ECONOMIST	FRANK H. LAHEY, M.D., Boston	173
FOUNDING OF THE NEW HAVEN COUNTY MEDICAL ASSOCIATION	CREIGHTON BARKER, M.D., New Haven	180
ASPECTS OF THE NARCOTIC PROBLEM	JOHN H. FOSTER, M.D., Waterbury	183
THE NEWER INSULINS	BARNETT GREENHOUSE, M.D., New Haven	189
VOCATIONAL REHABILITATION OF THE DISABLED CONNECTICUT WORKER	E. P. CHESTER, Hartford	191
A FAMILY HISTORY INFLUENCES TREATMENT AND PREVENTION	MAUDIE MARIE BURNS, M.D., Hartford	207
CLINICAL INTERPRETATION OF BLOOD IODINE LEVELS	D. S. RIGGS, E. F. GILDEA, AND E. B. MAN	209
AMELANOTIC MELANOMA (CASE REPORT)		193

EDITORIAL

Progress by Metamorphosis	210	Academy of Pediatrics Meeting in New Haven	211
Cancer and the Women's Field Army	210		
Non-Repetative	211		

DEPARTMENTS

ASSOCIATION OF CONNECTICUT TUMOR CLINICS—18th Meeting	197	THE DOCTOR'S OFFICE	223
FROM THE SECRETARY'S OFFICE	212	LEGISLATIVE SECTION	225
CONNECTICUT HOSPITAL ASSOCIATION	214	NEWS FROM COUNTY ASSOCIATIONS	233
MEDICAL PREPAREDNESS SECTION	218	NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE	234
CONNECTICUT SELECTIVE SERVICE	221	QUARTO NOTES (Book Reviews)	238
THE FORUM	223		

MISCELLANEOUS

OBITUARIES		SPECIAL NOTICES	236
George William May, M.D.		OFFICERS AND COMMITTEE CHAIRMEN	
D. C. Y. MOORE, MD.	235	Connecticut State Medical Society	4
J. Tyree Woodson, M.D.		Connecticut Hospital Association	4
JAMES E. DAVIS, M.D.	235		

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THE RELATION OF THE DOCTOR TO THE HOSPITAL

JAMES RAGLAN MILLER, M.D., *Hartford*

The Author. A.B., Yale 1907. M.D., Johns Hopkins University, 1911. Assistant and Visiting Obstetrician and Gynecologist, Hartford Hospital, 1915 to date. Chairman of Council, Conn. State Medical Society, 1940 to date

AMONG THE MANY CHANGES which are taking place with almost kaleidoscopic rapidity in modern society are those which are occasioned by the great increase in hospitalization. Apartment house dwelling is partly responsible for this but the chief cause is the increased complexity of modern medical care which only the hospital can offer. In 1653, Baltasar Gracian said, "More is demanded to produce one wise man today than seven formerly; and more is needed to deal with a single individual in our times than with a whole people in the past." How truly can the same be said of the physician and the patient of today!

An adequate discussion of the subjects suggested by the title would call for a long monograph. It is my purpose, however, to limit the discussion to a few phases. It is not necessary to consider such relationships in hospitals operated by the Army and Navy and Public Health Service, and by the state hospitals for the insane and tuberculous. As far as the individual doctor in these hospitals is concerned, "Theirs not to reason why".

The same may be said of the hospitals operated by railroads and industries, and by proprietary groups of physicians, e.g., some of our well known clinics. In the university hospitals, where authority is exercised by the faculty of the medical school, chiefs of service in their capacity as professors have much to say about policies and practices, but the foremost consideration is usually what is best for the medical school and discipline is rigid.

In sectarian hospitals, staff physicians participate to a varying and often limited degree in shaping the policies and practices which govern the relationship of the doctor to his hospital. It is, however, in the non-sectarian and privately endowed hospitals that we find most highly developed a real partnership of

lay and professional groups. Here, again the ultimate authority and responsibility for proper care of the sick rests, as it always must, in the hands of the lay board of trustees. Strictly professional matters, however, such as staff organization, the election of staff officers, the formulation of policies which relate the doctor to his hospital, and which regulate the details of medical care, all these are developed by, and are agreeable to the staff doctors.

This pattern of organization is found in most American community hospitals. It must be remembered, however, that here, as in all situations where there is a so-called democratic control, there is some loss of efficiency as compared with situations where a benevolent dictatorship controls.

Based on experience, a few general principles may be stated which should govern the partnerships of lay and professional groups in the conduct of community hospital service.

1. No member of the active staff should be a member of the board of managing directors. Such a relationship is not healthy for either the lay or professional group. The directors come to lean on "their" staff member and he becomes the all powerful influence in the institution. So much power is not good for any man.

2. Nominations to the staff, discipline of staff members, election of officers of the staff, and adoption of staff by-laws should be the prerogatives of the staff. Appointments made by the board of managing directors should be made only on the nomination by the staff. The directors should back up the staff with the full weight of their authority.

3. As in any matrimonial venture, attention should be fastened upon making a success of the partnership and upon gaining a clear understanding of the sphere of activity of each group. This will obviate most of the difficulties of the administration in staff relations.

It is interesting to contemplate the many instances in which fundamental tenets, supposed to be dear

to the heart of organized medicine, are transgressed in institutions which are nevertheless in thoroughly good standing. The free choice of physicians has already been modified and, in fact, has never been a privilege of ward patients. Another tenet is that no third party must come between the physician and the patient in their financial dealings. Here, again, the business manager has become an accepted part of many prominent clinics, and organized medicine has frequently honored with high office physicians who operate under such conditions.

In the early days, doctors learned by apprenticeship with an older physician or gained their experience on their own long suffering patients. Later, medical degrees and hospital internships began to be required in many states, recognizing the desirability of a course of training and of a supervised apprenticeship. In the last few years, it has been recognized that a long period of training is necessary for the adequate preparation of a specialist. Hence, national boards of certification in various specialties were established, and there have developed very definite schedules of training which are required for certification. These higher standards are influencing the internal staff regulations and are causing changes which will be considered later.

We are apt to forget that the doors of our hospitals were opened to the private practice of medicine only a few years ago. There has, until recently, been no place in hospital life for payment of the physician, except in certain fields such as laboratory, anaesthesia, x-ray, etc. As long as the hospital clientele was confined to the indigent class, the doctor-hospital relationship was simple. Hospital funds were usually obtained from patrons for the support of the needy, with no provision for payment of the physician. We are beginning, however, to see legacies and donations which contemplate a provision of medical care for the middle economic group which can pay its way, and which wishes to pay the physician. Expenses of modern care have to be subsidized, or cheapened to meet the needs.

Many adjustments have already been made, for example, in the care of compensation cases and if the experience in this field is any guide, it seems certain that the insurance factor in other branches of medicine and surgery is bound to bring about changes in the hospital-doctor relationship.

Some hospital staffs have already required that all heads of services hold certification by one of the National Examining Boards in the specialties. This

I regard as premature. One must, of course, demand a license by the State Board of Examiners, and a degree from a recognized medical school. It would seem, however, that beyond those two demands it is a wiser policy for the individual staff to retain within itself the power of choice, at least until such time as National Examining Boards are more perfectly integrated into our professional life. It is quite possible, at present, for an able specialist to fail of certification for some technical reasons, that do not impair his usefulness to his hospital. Until such time as the certification boards are recognized legally, and it may well be a few years before this happens, the individual staff should set its own criteria.

One of the relationships of doctor to hospital that is often misunderstood by laymen is the extent to which the hospital as a corporation is legally responsible for accidents which are the basis of malpractice suits. The subject is complex, but it may be broadly stated that a patient who pays his doctor and his nurse may bring suit against them as professionally trained individuals for alleged neglect in the performance of their functions. If, however, physicians are employed by the hospital on a salary, it will be the hospital which will carry protection for malpractice by any of its employees. It follows, therefore, as does night the day, that the lay board will not enter into such salaried relationships with physicians unless the hospital as a corporation has a controlling influence in the selection and in the discipline of its salaried employees. The number of staff members would therefore be reduced, selecting those who would not only be most likely to do the best work and thus enhance the hospital's reputation but also those who would be least likely to cause damage suits. The adjustments of this feature of doctor-hospital relationship will perhaps be the most difficult problem in the development of full time specialist staffs, and its proper development is dependent upon the successful application of the principles of joint responsibility which are mentioned above.

In the life of any hospital there may be a period of efficient management, during which the doctors tend to their professional work without much, if any, thought of the responsibilities of staff organization, and of the necessity of organizing to meet the changing economic order. When, however, the superintendent is either inefficient or incapacitated, there may be a period when the lay board is brought most intimately into contact with the staff in order

to close up the gap. Such experiences are healthy, and make for a better understanding in each group of the problems of the other. With such mutual understanding adjustments may be made step by step though changes should originate in the staff.

I believe that the future hospital will give increased attention to the opinion of courtesy staff members, especially calling upon those who send to the hospital numerous ward and private patients. Their points of view, their difficulties and their criticisms should be studied, and they should be absorbed into the hospital life as integral parts of the community program for medical care which centers about the community hospital. Post graduate education will develop about the hospitals as centers, relieving the medical societies of a large part of this burden.

I should like now to indulge in a little speculation. This may not be worthy to be classed as prophecy but at least it will set down changes which, I think, are likely to occur in the next years. To some of these changes I shall find it hard to adjust myself, and I do not wish to be understood as advocating this whole program. Wiser men than I have failed in similar prophecies, but I respectfully submit the following sketch as a means of provoking thoughtful speculation. Such changes will undoubtedly be violently resisted, most of all by specialists and the older physicians. Such opposition, if it is not blind intransigency, is very desirable, for as long as we maintain our present forms of government, changes should be adopted only when they have passed closest scrutiny and overcome critical opposition. It is hoped that physicians will meet this challenge dispassionately with wisdom which is needed if we are to be successful.

The future internship in a large community hospital will give two years of training. The first year will be of the rotating type, the same for future specialists as for general practitioners. The family physician group will in the second year continue in obtaining experience in diagnosis and skill in the treatment techniques which can be used in the office and the home.

During the second year the family physicians candidates will not be bothered by surgical work in which they have no special interest and these opportunities which they use up at present will become available to the specialist group which needs them badly in its program.

Following the internship the family physicians

candidates will be attached to out-patient departments in their hospitals and will become an integral part of the hospital organization while at the same time practising as at present in office and home. They will make all primary contacts with patients except in case of emergencies. They will operate on a fee system, for no salary arrangement will prove satisfactory for this type of service.

Community hospitals will cease turning out the "Jack of all trades" who aims to be a surgeon as soon as he has built up a general practice. In our thickly settled communities the future is not bright for the "Jack of all trades" type of physician. The general practitioner will, however, be the only free man in future medicine and as such his position in society will be relatively more attractive to the independently minded physician than will be that of the specialist.

The second or specialist group of internes will continue in its second year to rotate in the surgical or other special departments which will assist them in their chosen fields. After the second year a choice will be made, based on aptitude and previous record, of one candidate for each residency. Each man so chosen will work up through a prescribed period of two or more years spending his last year as resident in his special field. With this training he will then be ready for certification by his Specialist Examining Board.

During this whole period of training, first as interne and later as resident, increasing salaries will be paid for the service rendered the hospital. The resident will be started at \$1200 a year, and during his final year he will receive \$2400 to \$3000 a year. This plan will eliminate the present profiteering in the use of residents and internes. It will open opportunities to others than those who come from wealthy families and it will permit earlier marriages. Funds for payment of the residents will come from insurance payments of ward patients. Most ward patients will carry insurance which will cover the actual cost of ward service (\$4.00) plus one dollar per day for professional care. This dollar will go toward payment of the residents but this charge will be remitted in those cases where the hospital itself gives the patient a discount or even totally free service. The staff will derive no professional income from the ward patients. After the resident finishes his training, he will be given a salaried position in his own or some other hospital, and will eventually work up to an ample salary as head of his particular department.

The specialist and general practitioner will occupy positions as regards conditions of work and emoluments somewhat analogous to the positions of judge and attorney in the legal profession.

I have drawn this picture of development, beginning with the internship and residency, because changes should come first among the younger physicians before the older ones are affected. It appears that the pattern of specialty certification and residency training is on solid foundation. Opportunities for training the needed specialists in this country can be obtained only by making use of many of the large non-teaching hospitals. It follows, also that the number of specialists in any field will be strictly controlled. Crowding in surgery is dangerous, for it brings about ruinous competition on the one hand, and on the other, leads to unnecessary operations. A hungry surgeon may become a very dangerous surgeon. One of the most difficult problems in the future will be to obtain a formula which will limit the number of specialists and at the same time escape prosecution as a "combination in restraint of trade."

The position of the specialist in the future hospital will be like that which obtains today in the university hospital. The problem will be to keep the well trained specialist comfortably busy at such salaries, and under such condition of work as will give the highest type of productive service. Those specialists who depend on the hospital for their workshop, will be paid by salary. The control over these salaried physicians will be developed under mutual control of lay board and senior departmental heads and it may be that general practitioners and representatives of the patients in the community may have something to say in this matter. Specialists in the future hospital will have no primary contact with their patients.

General practitioners will have no opportunity for fee splitting, for they will refer patients to the hospital and the patients will be cared for on the appropriate economic levels by the staff, just as the ward patient is now received and cared for without free choice of doctor, in other words, they will refer patients to their local hospitals in the same manner that they do now to metropolitan clinics. The specialist's bedside manner will mean little compared to experience, skill and sound judgment. For the general practitioner, on the other hand, human nature being what it is, a pleasant charm will be a great asset.

In the future hospital the patient will not be sent in by his physician with a ready made and sometimes incorrect diagnosis. He will not always be admitted forthwith to a hospital bed, but will have the advantage of full laboratory, x-ray, and other diagnostic work in the ambulatory division of the hospital on the appropriate economic level. If the general practitioner is able to carry on the treatment which is found necessary, using the skill and equipment which he has acquired, no treatment will be given in the hospital, or in its clinic. Admission to the hospital will be reserved for those cases which need to be put to bed for treatment or diagnosis. Experience in the ambulatory type of diagnosis and treatment will be acquired by the general practitioner in the out patient department on the ward level. For this work small salaries will be paid. Specialists who work in the diagnostic department, where the best brains on the staff must be gathered, will likewise be on salary and the scale of payment will be in proportion to the economic levels of the patients and to the amount and importance of the service rendered.

Many physicians are puzzled that so many patients forsake their own community doctors and go to metropolitan centers for treatment. This can be understood if three factors are kept in mind:

1. Metropolitan clinics are very adroit advertisers. In these days when weekly magazines and monthly digests carry the latest medical discoveries, big rewards are reaped by clinics which can remain in the limelight. The advertising is always ethical and is especially adroit in presenting well prepared lectures at medical gatherings, and in sending to hundreds of physicians the printed reprints of such lectures.

2. The old-fashioned rotating service plan which still obtains in most community hospitals is best calculated to prevent any staff member from acquiring special skill and also special reputation in any subdivision of his field. Comparatively few hospitals have been wise enough to meet competition of the large clinics by cultivating local reputations.

3. Many people are "sold" on the idea of the thorough yearly physical examination. To them the criterion of thoroughness is an elaborate x-ray and laboratory check up. Local habits of intense individualism in medical practice make such examinations costly. The large clinic, however, has organized to meet this demand at a fixed price which is moderate. As a matter of fact the demand was

largely created by these clinics. Little profit is made on this diagnostic service, but the clinic obtains a hold on a large clientele which becomes convinced that the only safe place for treatment is in the clinic which they have visited.

Consequently, I foresee that the future community hospital will offer to the public complete diagnostic service at reasonably low and fixed prices. Second, that within these hospitals individual physicians will be given special assignments with continuous control of certain types of cases, so that they may gain skill and reputation commensurate with that of the metropolitan clinic physicians. Third, that by means of ethical but none the less effective advertising, the professional and lay public will be made aware of the skill which is locally at their disposal.

In this consideration of the hospital-doctor relationship, many things have been omitted and perhaps others have been over-emphasized. It is my sincere hope, however, that the opinions of the medical profession may become less confused on some of these subjects and that changes which may be brought about, will be made in a manner agreeable to the medical profession. Only by thoughtful planning can this be done.

Pan American Congress of Ophthalmology Organized at Cleveland Meeting

Pan American relationships took another step forward in the field of medicine when the Pan American Congress of Ophthalmology was organized on a permanent basis at the meeting of the first Congress in Cleveland, October 11-12 under the auspices of the American Academy of Ophthalmology and Otolaryngology.

Doctor Harry S. Gradle, Chicago, was elected president of the congress. Doctors Conrad Berens, New York, and Moacyr E. Alvaro, Sao Paulo, Brazil, who served with Doctor Gradle as members of the committee that organized the initial meeting, were elected executive secretaries.

Montevideo was tentatively selected as the place of the next meeting, to be held in 1943.

Eighteen delegates representing governments, universities, hospitals and medical societies in Brazil, Chile, Costa Rica, Cuba, Colombia, Guatemala, Panama and Puerto Rico were present in Cleveland. An extensive program of scientific papers was presented, about equally divided between English on one hand and Spanish and Portuguese on the other. English papers were discussed by Latin American speakers; those in Spanish or Portuguese by the English speaking physicians.

The Family Doctor

"For my part I am still unconvinced that the family doctor is an anachronism. I still want somebody to save me from unsuitable or excessive specialist advice; I need someone to coördinate the findings of specialists and discount them if necessary; and above all I want someone who is willing to talk to me, at length, about my migraine, my little boy's delinquencies, my wife's recent strangeness, my baby's inoculation, and my daughter's desire to marry a man with asthma." Lancet. Copied by the New York State Jour. of Med., Jan. 1940.

Announces Two Special Exhibits for A.M.A. Cleveland Session

The Committee on Scientific Exhibit of the American Medical Association announces that there will be two special exhibits at the Association's Ninety-Second Annual Session, to be held in Cleveland June 2-6, 1941.

These special exhibits will be on fractures and on lame backs. The Special Exhibit on Fractures will be presented by a committee headed by Kellogg Speed, M.D., Chicago. Dr. Speed will be assisted by Frank D. Dickson, M.D., Kansas City, Mo., and Walter Estell Lee, M.D., Philadelphia.

Frank R. Ober, M.D., Boston, is chairman of the committee which will sponsor the Special Exhibit on Lame Backs. Other members of this committee, who will work with Dr. Ober, are Carl E. Badgley, M.D., Ann Arbor, Mich.; J. Archer O'Reilly, M.D., St. Louis; Arthur Steindler, M.D., Iowa City, Iowa, and Philip D. Wilson, M.D., New York.

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REMARKS ON EFFICIENT TRACTION

H. W. WELLINGTON, M.D., F.A.C.S., *New London*

The Author. M.D., *College of Physicians and Surgeons, Columbia University, 1913. Orthopedic Surgeon, Lawrence and Memorial Hospital, New London, 1930 to date*

TRACTION for the treatment of fractures is hundreds of years old. During these centuries many methods have come and gone and have revived from time to time until today. The latest improvements have come from more efficient methods of applying to the anatomical part on which it is wished to pull, an improved dressing or a mechanical device to which may be made fast the traction apparatus. Moleskin for skin traction as well as other skin methods have been greatly improved. The skeletal apparatus, pins, wires and clamps are relatively new.

Practically, you must develop the type of traction apparatus with which you can get good results. You can run into more trouble in trying to do things the way someone else does than you will ever have in developing your own way as long as this method is basically sound.

If traction is used in cases that are not suited for it, unsatisfactory results are bound to follow.

In suitable cases use a method that you can apply easily, quickly, and with the least possible shock and discomfort to the patient who in a large percentage of cases will reach you following improper or no first aid treatment, especially after many automobile accidents, when seriously injured people are dumped into a passing car and driven to your hospital with a celerity that often increases the trauma. This shouldn't happen but it does with great regularity.

To me, single and double block traction has seemed the most generally satisfactory and is not only simple to apply but also easy to run, flexible, comfortable for the patient, and requires the least adjusting of any method I know. The direction of pull is easily checked and x-ray views are readily taken. To apply it well, it is necessary to observe the following requirements:

1. No obstruction to the traction. This is commonly caused by the foot piece of the bed, by a poor type of bed spring or bottom, by pulleys attached too close to the part that is in traction and

to each other, and by complicated hook-ups, where simple methods are better.

The problem of keeping the weights from touching the floor is overcome by rigging the weights high up and clear of any obstruction. Watch out for the chair shoved in under the weights! A Gatch type bottom is best. The foot of the bed is easily removed with a hack-saw if necessary.

2. Ease of adjustment. This simple need is often made difficult by making parts fast permanently by tacks, nails, or screws, when clamps of some type that could be loosened with a twist of the wrist or fingers could be substituted.

3. Automatic adjustment with change of the patient's position. All pulleys should be self-aligning either by universal or swivel joints or by being tied with a sufficient length of flexible cord to give this effect.

4. Friction of apparatus made minimal. Use pulleys of good construction with large sheaves and small flexible line. The mistake of small blocks bought because they are cheap is common. Sailors hate "small blocks and big ropes and light winds and variable, that's what makes 'em holler". A good place to find satisfactory pulleys is the ship chandlers, the rigging and sail lofts, the awning makers, or the best hardware stores. I use sheaves with a 2½ inch diameter.

5. No overtraction. Keep traction as near that required as is possible. Overtraction requires too much counter-traction which may result in an uncomfortable patient who is more open to complications, may make nursing procedure more difficult, and may cause distraction of the fragments, joint overstrain or ligamentous lengthening, thus complicating the injury and prolonging convalescence.

6. Mobility. Is obtained with the above requirements and gives comfort, a much easier and better nursing chance, and decidedly better end results.

7. Good rigging. If you can't rig and tie knots get someone else to do the job, then improve your time learning to tie a square knot, a clove hitch, and a bowline. A summer of yacht racing is good knot training.

Having applied the traction, align the fracture by

the simplest method, which is a piece of string carried out beyond the thigh in the line of the shaft of the femur or beyond the forearm in the line of the shaft of the humerus. When this bisects a parallelogram erected on the leg, top side in the case of the femur and the forearm, bottom side in the case of the humerus, your apparatus is approximately in the correct position. Then check position of fragments by x-ray and adjust from here on by x-ray check until the position is satisfactory. When it is impossible to get a proper position, which occurs in a small percentage of cases, shift to some other method which works.

Inasmuch as the patient never stays in exactly the same position for more than a short time, for this method is very mobile, and since the direction of pull necessary varies with each fracture, due not only to its type but also to the fact that the soft parts injuries are always different, any adjustments depending on a mathematical formula are impossible and you must rely for practical results on the

method of trial and error, but not on "by guess and by gosh".

There is a proper timing in the healing of fractures. This means that reduction should be obtained in a comparatively short time, so for this, use weight enough to get it. For example, in a fracture of the femur in a husky, muscular individual it may be necessary to start with a weight of eight to ten pounds giving a traction of sixteen to twenty pounds. As soon as the reduction is complete, which is usually within twenty-four hours, let up on the traction until it is amply sufficient to carry the fragments in the reduced position, which in the average case will be about a twelve to fourteen pound pull. In a weak, a small, or a poorly developed patient relatively less will be required.

It is far better to keep the traction going a little too long than not long enough. When you think the time has come for the removal of traction, try it off for a few hours at first and then for longer periods, and if it is found that this causes no untoward



FIGURE 1

Female, 35 years, compound fracture both bones right leg, internal abdominal injuries, multiple superficial injuries. Kirschner wire through os calcis, single and double block traction of Russell type, alignment of leg maintained by short moulded posterior splint to leg, bridle on wire counter-balanced by three pound vertical pull. The single block attached to the bridle has a swivel joint and aligns itself in any position without throwing any twisting strain on the leg.



FIGURE 2

Male, 21 years. Transverse fracture left humerus, posterior dislocation of the left hip, fractures of three right metacarpals, multiple superficial minor injuries. Reduction of hip under an anesthetic, left leg then put up in traction of the Russell type in abduction until spasm had subsided and hip motion was complete and painless. Single and double block traction on left humerus until reduction and early union. The left side of the bed has been raised six inches to secure comfortable counter-traction.

symptoms a complete removal may be made. Reliance on good callus plus muscle recovery and good soft parts healing pays far better dividends than those obtained from braces or other artificial sup-

port. The purpose of treatment is for a final good end result and not any record for few hospital days.

The photographs show how the requirements for efficient traction can be met with simplicity.

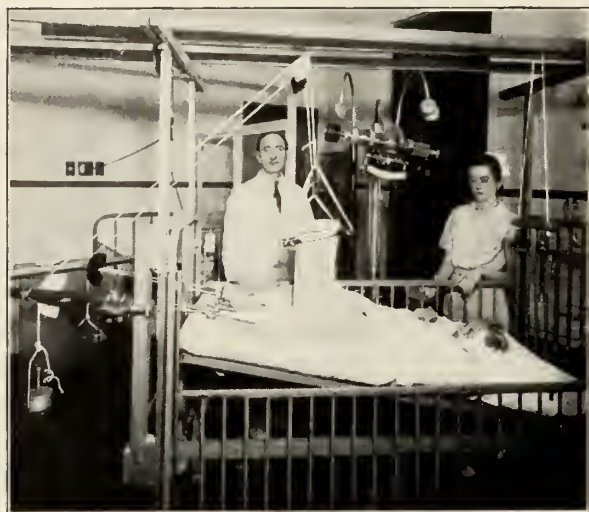


FIGURE 3

Boy, 7 years. Transverse comminuted fracture middle of left femur, oblique fractures right femur, one at junction of middle and upper third, and one at junction of middle and lower third. Cerebral laceration, lacerated wounds of head and neck. Youth's bed, wooden frame, Russell type traction both legs. Counter-traction by raising foot of spring.



FIGURE 4

Girl, 11 years. Transverse fracture upper end right femur. Balanced Russell traction in adduction. Counter-traction by screw jacks in the posts of the bed. Weights are rigged high.

Loan Collection for Speakers

The Bureau of Health Education of the American Medical Association offers to local physicians the loan of prepared material for speakers addressing lay audiences. Even though a physician may be an able speaker, he frequently hesitates to accept invitations to speak before lay audiences because time is required to prepare material in suitable language for such audiences.

It is here that the *Hygeia* Clipping Collection loan service is of value. These collections consist of *Hygeia* material. They are patterned after the American Medical Association's Package Library. The advantage of this material is that it is written in non-technical language that the layman can understand. Thus, the physician is saved the effort of translating technical material into language easily understood by non-medical groups.

There are collections available on 82 topics; accompanying most collections is a speaker's outline. This outline is not intended as a fixed pattern which

the speaker must follow but is merely offered as one way in which the material may be presented. As the physician reads the clippings, he may make his own notes on the outline and use only that portion of the material appropriate to his community.

The collections may be borrowed for a 10 day period and the only charge to the physician is the return postage for the bound material. Collections should be ordered at least two weeks in advance, and first, second, and third choice should be indicated since collections are not always available.

The demand for this material has grown tremendously the past several years. Several state medical societies, as well as a few county medical societies have found it to their advantage to develop speakers bureau library services of their own. In spite of the great demand for this material and the amount of publicity it has received, there are still a number of physicians who are not acquainted with the material offered by the Bureau. The practicing physician is not always a polished platform orator and welcomes aid of this type.

SOME ECONOMIC PROBLEMS BY A NON-PROFESSING ECONOMIST

FRANK H. LAHEY, M.D., *Boston*

PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

I DON'T MIND speaking about medical subjects. In fact, I like to. I have no hesitancy provided I am permitted to talk about something with which I have had experience; and I like post-graduate teaching, but when I am asked to make an after-dinner speech or to talk on medical sociology or medical economics, I do not have the same confidence because I do not have the background of experience from which to draw. Therefore, I say that I hope you have enjoyed the dinner, because I am not at all certain that you will enjoy what I have to say. That means that I am far from satisfied with my ability as an after-dinner speaker or an economist. That is the reason I gave this title. Now, this title, I know, is funny—I mean funny in the colloquial sense. It is really funny when I try to be an economist, even a non-professing one.

But before I talk at all about any of these subjects, it seems to me, because I have been honored with the position of President-elect of the American Medical Association, that I should say a few things about the American Medical Association. I know that these are critical times and times of criticisms, and the thing that I have always said to myself whenever I have been criticized is that it is certainly a very definite indication to me that I should review some of my actions and some of my views and at least determine whether or not the criticism was not justified. And I feel very sure that that is the situation as relates to organized medicine. I don't think that organized medicine in any way ought to resent criticism. I think it ought to welcome criticism. And I am certain in addition to that that rarely does criticism exist that it doesn't bring about better conditions; if it does no more than to stimulate the interest on the part of the one criticized to review the situation, it does good, and to review so often brings about changed conditions which are of advantage.

Now, on the other hand it has been said by George Vincent, you know, that most people don't reason, they just rearrange their prejudices.

There are, I think, criticisms likewise which are not justifiable, and it is very easy to get the point of view that the present is not as good as it could be and that the future and the distant horizons always

look rosy even though the detail is not clear. And so I think it is well for all of us to remember—not that I present this as an argument against criticism—what is going on with medicine.

Just the other day one of my own pupils whom I have trained and raised spoke to me quite critically about some things in the American Medical Association and I said, "How much do you know about what goes on in the House of Delegates? How much do you know about the effort that is put in by the representatives in the House of Delegates? How much do you know about what goes on in the various councils and the various committees? How much do you know about what goes on in the way of real effort at the headquarters?" And he said he didn't know anything, which is, of course, too often true.

And so often so many criticisms are made without adequate information about what really is going on and what is really being done. I have suggested and it has been suggested before that the American Medical Association make more effort to disseminate more knowledge about what is being done. Many of these facts, I know, are very familiar to you; but after all, medicine is on a very good standard in the United States, when you realize that there is one doctor to 767 people, as compared to one doctor to 1,061 in England, and that really runs up to one doctor to 3,500 when you get to Czechoslovakia, and one doctor to 3,000 when you get even to such a well-organized though small country as Sweden. It is interesting to know that there were in 1927, 853,318 hospital beds; that in 1939 there were in this country 1,191,000 beds. And here is an interesting problem that we must all have in mind. It has been estimated that up to approximately thirty per cent of these beds are vacant most of the time. Now, one of the things we have to remember as we develop these new ideas is that some of these hospitals are having very difficult times getting along, and that their financial sources are gradually drying up. If, for instance, we build a great many hospitals—which undoubtedly is a good scheme in communities where there is a lack of hospital facilities—and increase hospital beds by a very great

number, these must be supported, and these vacant beds exist, and that will make it even more difficult for these hospitals, if they lose more patients to the other hospitals, to maintain themselves with more vacant beds.

When we get a double drying-up of income, there may even be greater hardships from the point of view of maintenance of these hospitals.

The death rate in the United States was in 1911 14.2 and is now 10.9. There are only two countries in the world who have lower rates than these, Australia and New Zealand. Diphtheria rates are, of course, very striking. You know that in German towns the mortality rate per thousand is 11.5. In English towns the rate is 8.6; in the United States, 1.5. In 1880 there were 100 medical schools turning out 3,241 students, and in 1939 there was a reduction to 77 good medical schools turning out 5,089 students.

After all, that doesn't answer the question. That isn't presented with any idea of contentiously refuting criticism, but it is, I think, a very desirable thing for us to realize, that after all, while we can still be critical of medicine in the United States and while we can still desire to improve it, and while there are undoubtedly people who are not receiving in certain districts as good medical care as they should, on the whole medicine in the United States is at a very high level.

When I begin to talk about the American Medical Association, I should also say something about preparedness, because the American Medical Association is playing a very great part in preparedness. It has been my privilege and duty to attend the national preparedness committee meetings which occur at the same time as the trustees' meetings of the American Medical Association in Chicago. I could not bring you anything in the way of news with which you are not already familiar. You know already of the questionnaires that have gone out. You know that the number of filed answers has gradually risen until it is now at a very high proportion of the total number of 179,000. And there is being prepared at the headquarters a plan whereby under the punch-card system all of the doctors available for service will be catalogued so that it will be possible as the government needs men to supply ready and complete answers regarding specialists, general practitioners, and so forth. You know also that the American Medical Association is now undertaking a second questionnaire to obtain infor-

mation regarding men who will be willing and able to render service to the industries which will undoubtedly require a good deal of medical attention.

I am very much interested, as everyone is, in the question of preparedness, and I am very much interested, as everyone is, in the attitude of the country concerning our immediate problem. I find various attitudes, as no doubt you do, but I cannot ever speak before any medical audience, it seems to me, without having it a very definite part of my duty to urge strongly upon everyone that we must not make the mistakes that have been made. I have repeatedly said, with an attempt to teach with a little facetiousness, that if this is not a real emergency that faces us now, it will do for me until a better one comes along.

I believe, as I said when accepting the Presidency-elect of the American Medical Association in New York, that regardless of whether or not this country will ever be attacked, if we are going to make a mistake, it should be on the safe side, and certainly the safe side is to so prepare ourselves, as we are setting out to do, on the basis that we will be attacked, and at least then the only thing we can lose is a little money. After all, since I am going to be an economist, what's a little money?

Now, if I am to talk as a non-professing economist, I should tell you a story which I have worn out by telling, because it illustrates what kind of an economist I am. There were two nitwits in a drug-store, one tending the counter and one who came in for a soda. And the nitwit who came in for a soda said to the nitwit who was tending the counter, "I'd like a soda." And the nitwit who was tending the counter said, "With what flavor?" And the other nitwit said, "Without flavor." And the first nitwit said, "Without what flavor?" (laughter). And the other one said, "Without chocolate." So he looked the lot over and said, "We ain't got chocolate so you've got to have it without vanilla" (laughter). So you really have to have me without capacity as an economist.

I have put down economists and sociologists here. I can't discuss sociologists particularly because I am a non-professing economist. I can say a few words about economists in general. Anyone can be an economist nowadays. There are, as you know, no qualifying boards for economists (laughter). One just sets himself up and starts writing, talking and advising, and he can do this with or without pay, depending upon whether or not he has in-

dependent means or has to earn a living. It is a great specialty, in my opinion. One does not have to be right practically at all. Very few economists ever lose anything themselves, so they don't have to worry. If they practice the specialty for money, they get paid anyway, and you take all the risk. If they do it for fun, they have the fun, and whoever heard of a malpractice suit being instituted against an economist? Furthermore, they don't have to carry protective insurance the way we do. And in addition to that, the world is just full of people who want advice and who are unwilling to think for themselves, and so the economist has a great field. In the face of all this, I don't see why I can't be an economist just as well as they can, particularly if I want to. Their record in Washington and out is so bad that I can't be any worse than they have been. I don't know very much about bridge, but I suppose that if one of these real bridge maniacs were to describe an economist, he might call him a "free double."

I thought that if I were going to set myself up as an economist, I would set myself up as a "barnyard economist", because, after all, if you run a clinic and you have a lot of doctors to manage, you have to be some kind of an economist to get on with them and to manage them.

There are a few fundamental economic beliefs that are not related to medicine solely, but on the other hand, they play a considerable part in medicine, that I think is of interest, and they have had to do with getting us into the situation in which we are economically today. There are just a few old-fashioned ones that I would like to mention. One is—and this is not related to medicine, but I was brought up on this—that you can't have what you can't pay for, and that is a fundamental economic law. Now, that doesn't mean in relation to medicine that the person without means can't have medical care, but it does have a great deal to do fundamentally with economics, and it has had a great deal to do with the distortion of our economic system. That means, as another fact with which I was brought up, that a mortgage is something that stays with you twenty-four hours around, and even goes to bed with you and helps to keep you awake nights. All of this has to do with installment buying.

Another point which my father taught me was that a contract was never unilateral, and it was always a moral obligation. One of the things that I am sure that young men—and I recall my own

experience in medicine—are a little intolerant of is the time it takes them to establish themselves in a community. Knowing that they are honest, that they are sincere and that they are capable, they often are resentful of the fact that this is not appreciated at once. It is unfortunately but desirably true that it takes time to prove one's honesty and reliability. And honesty is one of the things in medicine that is so absolutely essential. It is one of the foundation structures of medicine. I remember very well some time ago when visiting Dr. Crile in Cleveland coming down Euclid Avenue and every morning as I came down, in front of a filling station I saw a blackboard that had printed on it some funny little thing. Now, I felt, as I recall it, that dishonesty was like this little statement that I saw one morning as I went by. It was, "There is no such thing as a little garlic." There is no such thing as a little dishonesty.

Another fundamental economic law is that which applies so aptly to medicine, and that is, "There is no substitute for long hours and hard work." I think it is a misfortune that there is a tendency, it seems to me, to overlook the fact that long hours and hard work are the things that have built our characters and the characters of our parents. That doesn't mean that I am competent nor am I capable nor do I intend to talk about labor hours, because I am not capable of discussing that. But on the other hand, I have fundamentally established in my mind that one of the things that has made me whatever I am has been long hours and hard work, for which there is no substitute. I am also convinced that in these fundamental economic laws comes that of thrift and saving as character builders and waste and thoughtlessness as character destroyers.

All these very fundamental economic things have come up in my mind as the foundation structures upon which economics are built. Obedience in children up to the time of independence is a rearing essential, one of the things, it seems to me, that has been lost sight of a little today. Another is that religion is not a cloak to be worn but an inward light. I think that we shouldn't be too serious, and I think that as we talk of religion a little touch of lightness at times probably adds to the occasion. I remember very well at the New Hampshire State Medical Society some time ago I had to make an address to a mixed lay and professional audience not unlike this one, and Dr. Bazin, who is Professor of Surgery at McGill, sat next to me and he had to make a talk. He said, "Frank, I want to tell a funny

story but I don't dare to because it has a religious aspect and I'm not sure whether it will be all right." On my left was a bishop of the Episcopal Church and on my right a bishop of the Catholic Church. Well, I had taken the spleen out of the Bishop of the Episcopal Church so I knew how he'd stand for it (laughter). And I knew the Bishop of the Catholic Church pretty well and I knew he would be reasonable, and I knew that no longer is there religious intolerance, so I said, "Tell me the story and I will tell you whether or not you can tell it." And he told it to me.

There was an old English lady who had a relative die and leave her a thousand pounds. She went down to London to a travel bureau and she said to the manager, "I'd like to be assigned to someone who would arrange a short trip for me. I have a little money and I want to take a short trip to a very nice spot of the country, and I don't want to go into this country if I can help it. Will you turn me over to a young man?" So they turned her over to a young man and she didn't know that he was an ardent Irish Catholic. She said, "Young man, I have this money and I'd like to take about a three day trip. Where would you advise me to go?" He said, "I think you would like to go to the Bay of Quiberon. Sara Bernhardt's home is there. There are interesting relics there. It is in Brittany and the people still wear their native costume, and I think you would like it." She said, "I can't go there because I get sick crossing the channel." He said, "Then I've got to get you somewhere in this country. Why don't you go to the Trossachs? You can go to Loch Lomond and Loch Katrine." She said, "I've been there." He said, "I know just the place for you. It is only a short ocean trip and it is smooth. Why don't you go to the south of Ireland? It is God's country. The apple blossoms are in bloom and you will love it." She said, "No, I don't want to go there. That is wet and cold and full of Catholics" (laughter). He said, "All right, Ma'am, go to hell. That is hot and dry and full of Protestants" (laughter).

Now, when we come to the question of medical economics I think the mistake that economists, sociologists and social workers are apt to make, and businessmen and laymen are apt to make when they begin to judge doctors, is that they begin to consider medicine as a commodity. I have repeatedly said this and I think it is one of our difficulties. When you begin to consider medicine as a com-

modity, then you distort your viewpoint so that it can never be the same, it seems to me, as that of one who is in medicine. Medicine and business perhaps are as different as can be. It is well illustrated, for instance, by the development of the steam engine and the microscope, as has been well brought out in a little booklet on this subject by the American Medical Association. The steam engine, for instance, makes it possible to substitute this power for human labor; while on the other hand, the microscope opens up all new fields of scientific discovery without in any way influencing production in terms of manpower. Medical progress, for instance, is not dominated by inventions but by scientific discoveries, in contradistinction to the results in business. Business is largely influenced by these discoveries and inventions, while medicine has been influenced by the discoveries of Jenner, Harvey, Lister, Koch, Pasteur, Banting and so forth. These discoveries have been scientific discoveries that have advanced medicine purely in terms of science. Industry has subsidized men in a measure to machinery. In medicine the contact is quite different. A commodity is something that must be developed by machinery, by manpower. It must be advertised. It must be sold. It must have a certain degree of pressure salesmanship behind it. Medicine is entirely different. The effect of medicine is established by direct contact, and no matter what we do, the sum total knowledge of medicine must flow from individual to individual and never by groups, and never by mass production and never by high pressure salesmanship.

The competition in medicine is utterly different from the competition in business. The competition in business can be in quality, but tends to be a price competition, and regardless of quality eventually in terms of its dissemination reaches finally a matter of price competition. Medicine never reaches price competition. It never should reach price competition, but only quality competition. There is, I think, the outstanding difference between medicine as a commodity and medicine as you and I know it.

Medical capital is knowledge. Business capital is machinery, buildings, equipment and money. The sum total capital of medicine is the sum total of knowledge. Unlike business, medicine does not act as an owner. No one can own the knowledge in medicine. One can only be a trustee of that knowledge, and that trustee is interested in weeding and winnowing and selecting and putting into the

capital that which by individual effort has been discovered, that which has been thoroughly tried out, approved and finally selected as worthwhile of being put into the central bank of medical capital consisting of knowledge.

In medicine everything unreservedly is pooled. I think I wouldn't even need to mention a funny story in order to stress this fact. Nothing is concealed in medicine. If you have something in the way of an operative procedure and I come to visit you, you take the greatest delight in showing it to me in every detail. If you come to visit me I get you a high stool and put you over my back and take all the pains I can to point out to you every detail of anything that I have developed, with the hope that you can take it home and employ it, or you can think it over and reject it. But it is never concealed.

It is unlike the two Jewish gentlemen who were playing golf and came up to the eighteenth hole all even, with a dollar at stake, stroke for stroke. And Abie said to Izzie when Izzie pitched one close to the eighteenth hole pin, "Izzie, what number iron did you use?" And Izzie says, "Does Gimbel tell Macy?" (laughter).

One of the problems that always comes up in this question of the discussion of medical economics is the problem of medical care being so largely related to the purchasing power of individuals. It is true probably that more than half of the families in the United States have incomes of \$2,000 or less, and it has been urged that since this could not be changed, what should be done as to changes in medicine? One of the things I think we must not forget is that there is a danger in these changes—and this is what the doctor seems to worry about. Some of the things we read in the paper from time to time about this disturb me at times. Papers often imply that there is on the part of doctors resistance to the progress of medicine and that implied idea is denied by every action of a doctor, that is, the idea that the doctor is afraid he is going to lose something and so he resists any change in the type of medicine. That really could not be so when one realizes what the life of a doctor is and what the doctors have done. He really deserves better consideration than that. He resists it not because he is afraid that he is going to lose his practice. He resists it, I am sure, because he fears for the quality of medicine. That refers to the outstanding majority. There are exceptions to every question. He fears

that the quality of medicine as the result of these changes will be injured. He doesn't particularly fear that the injurious effect will be upon his income or his position. I am sure that as I talk to men who fear some of these changes, they fear not the changes but they fear the danger of sudden changes. They fear the unsuspected results that may accompany sudden changes and they fear its effect upon the quality of medicine. And that is one of the things, I feel very sure, that should be put before the public lest the doctor be put in a wrong light.

He looks to the places where some of these experiments have been tried in other lines and in other countries and he is fearful lest some of these unsuspected developments occur in medicine which today is in such a good state in this country.

Now, that is by no means presented with any idea of implying that medicine is completely satisfied with itself, that there is not a necessity for some changes and that changes should not be seriously thought over and contemplated. It is, however, my very definite conviction that I would like to see medicine change slowly and largely by evolution rather than by radical and sudden changes, because I have more trust and more faith in the evolutionary changes in that they permit consideration of complications as they arise, offsetting undesirable effects as they become evident and preventing the occurrence of some of these defects which have occurred in other lines where sudden changes have been brought about.

We come next, of course, to the question of medical insurance. I have before me here on the table the enabling act which goes to the Massachusetts Legislature today to enable the Massachusetts Medical Society to organize, or to enable under the guidance and advice of the Massachusetts Medical Society the establishment of a group for medical insurance. Medicine has no objection whatever to medical insurance, but I have certain convictions in my mind about medical insurance which to me are sound, and they are these: I think most people are improvident. I think it should be possible by actuarial means to provide medical care, and good medical care, for people who today find it a hardship to pay for good medical care, even though they pay in very limited amounts and I think that the amounts which will do it are probably within the means of most people, and the others have to be taken care of. Pretty nearly everyone admits today that exclusive of the communities where there are

no hospitals the very poor are pretty well taken care of.

Any medical plan, to my mind, that is a sound one should be sound financially, and that means that it should be willing to submit itself to the same regulations as others under the commission established to ascertain soundness and maintenance of soundness, by the Commissioner of Insurance in every state. That is one fundamental fact. The next thing is that it should set certain limitations of income for those groups who come under this insurance plan. I have no argument about the amount so long as a reasonable one is set up with which everyone is satisfied. The third one is the one which causes so much debate and that is the free choice of doctors. I have repeatedly said that I would myself stubbornly maintain that any insurance plan to work should permit the free choice of doctors. One of my friends in Massachusetts, who is a good friend and with whom I disagree, came to me and said, "Frank, I would agree with everything you say if you will add one word to that, and that is the free choice of 'qualified' doctors." I said to him, "That is the rock upon which you and I split." Who is to qualify them, and how do I know that the man who qualifies them is qualified himself? To qualify them, for instance, you are an outstanding medical man. Will you be qualified in your hospital to say who is a qualified surgeon? I doubt very much whether I, as a qualified surgeon, am capable of saying who is qualified as a consulting internist. I doubt it very much. I fear any plan whereby free choice of doctors is not permitted, even though the patient chooses a poor doctor. I would prefer—and this is just my personal conviction—that he have free choice of doctors even though he chooses a poor one. I have more confidence in elevating the standard of medicine by means of lay education and by improving the standard as is being done now by the qualifying boards. I believe it would be a little slower perhaps, but it would be a little more sound and it will work out ultimately with less hardship. So I can say that on the whole I personally have no objection to any insurance plan if it will fulfill these three requirements: (1) submit to the same oversight that other insurance bodies do; (2) that there be an established limitation, upper limit, to the income group; (3) that they have free choice of doctors.

Now, we come to the so-called medically indigent. I am certain that they exist, but I am certain

that linked hand in hand with any attempt to look after them medically must come some attempt to look after them economically. What good is it to look after them medically alone? I know some of these regions where the people are really medically indigent. I happen to like to shoot quail and I happen to have had a shooting preserve, ten thousand acres. It sounds like a millionaire, but it is only five cents an acre to maintain one down in that part of Alabama where the people are really medically indigent. But there isn't any good in overcoming their problem as relates to medicine if they are still on a pellagra diet. Their problem is as much an economic one as it is a medical one and really the primary one is the economic one. And so we come back again to just this thing that I think relates to all of this medical economics, and that is that it is a local problem, that it is one which should be dealt with by communities. It should be dealt with by the doctors. It is best dealt with by the county medical societies. It is best dealt with by the county medical societies because they know their problems. They know their people. They know their doctors and they can best meet their problems. If it is dealt with nationally, it will make many mistakes. But if it can be dealt with as a county problem or even as a state problem with subdivisions in counties, it can then function very successfully. If it meets these requirements it will, I believe, fulfill one of the very definite needs of the country.

You can regiment and control—I don't like the word "regiment" and I don't like the word "socialized." When I was asked, "What is socialized medicine?" I said, "Socialized medicine is just a term. It has done more harm than good. Regimented medicine, and many of these terms have done more harm because they have become fighting terms. They have become argumentative terms and they stir up animosities. That is one of the troubles and that if where I say that George Vincent is so sound in this statement that people don't reason, they just rearrange prejudices. I like to talk frankly. All the people in the Committee of 430 are my friends. I don't doubt their honesty. I don't agree with them about some things but I am sure their purpose is honest. And so we must have a frank and free and unprejudiced, unbiased discussion, and it mustn't be acrimonious discussion because it involves us all.

You can control medicine up to one most important point, and that is where the doctor comes in

contact with the patient. This knowledge flows by this single channel from him to the individual. There his honesty, his placing of professional standards often above personal standards, above personal interests; and his fundamental training and his interest in constantly improving his knowledge and ability are outside of any control but his own character and conscience. The development of these facts has been the tradition of medical progress throughout the generations, and whether we have any type of state medicine or anything else, medicine will only succeed when these facts which have made medicine as great as it has been in the past continue to maintain themselves in the future as they have in the past.

The Health of the Carolinas

The inaugural addresses of the two new governors of the Carolinas, Carl V. Reynolds of North Carolina and Burnett R. Maybank of South Carolina, are significant for their medical implications.

Governor Reynolds calls the attention of his people to the fact that North Carolina has come to be known the world over for its pioneer work in the fields of useful endeavor, "notably along the public health front." During the past four years under his predecessor, Governor Reynolds emphasizes the fact that the full time public health departments in the State have increased from fifty-seven counties and four cities to eighty-one counties and six cities. It is the governor's aim to establish such full time departments in all of the 100 counties.

At the present time the employment of every person in the State Health Department is now on a merit basis. The School of Public Health, established at Chapel Hill under the leadership of Doctor Milton J. Rosenau, formerly Professor of Preventive Medicine and Hygiene at Harvard Medical School and Director of the Harvard School of Public Health, now trains personnel for public health work in North Carolina.

The State Board of Health and State Department of Public Instruction have integrated their facilities in order to extend throughout the entire public school system "a coördinated, continued and uninterrupted service in training teachers what to teach in preventive medicine," and to help them to properly screen defectives so these may receive the special attention they merit.

During 1940 the State Board of Health of North Carolina completed its new laboratory of hygiene, consisting in addition to a downtown building a 280 acre farm west of Raleigh, the entire project representing an investment of \$320,000. It also sponsored two bills which were passed, one requiring that both parties to marriage submit to serologic tests, the other that all antepartum patients be required to have such tests made.

In South Carolina Governor Maybank commended his State Health Department for its excellent work and its coöperation with the Selective Service. The outstanding health note in Governor Maybank's address was his emphasis on the need for more attention to the venereal disease problem. He is requesting the passage of laws making it a misdemeanor for anyone with venereal disease to go untreated, and requiring a physical examination of all marriage applicants together with the filing of a doctor's certificate.

New Color Film On Vitamin B Complex

The apparently high incidence of sub-clinical deficiency states associated with lack of the vitamin B complex and the difficulty of recognizing and diagnosing such conditions make the announcement of a new motion picture on the vitamin B complex one of special interest. The title of the new film is "The Vitamin B Complex;" it is entirely in 16 mm. Kodachrome. A *sound* as well as a *silent* version is available to medical societies and medical schools.

The film is based largely on clinical material from the Nutrition Clinic, Hillman Hospital, Birmingham, Ala. The cases selected for the most part were not so much those exhibiting the classical syndromes, but rather were of the mild type frequently involving mixed deficiency states and less endemic in character.

The film was produced under the supervision of the scientific and medical staffs of E. R. Squibb & Sons, and was reviewed before release by authorities of international repute in the field of medicine and nutrition. There is no advertising in the film which is offered solely as a conservative review of the present status of the subject. Inquiries with reference to the loan of the film may be addressed to E. R. Squibb & Sons, Professional Service Department, 745 Fifth Avenue, New York, N. Y.

THE FOUNDING OF THE NEW HAVEN COUNTY MEDICAL ASSOCIATION

CREIGHTON BARKER, M.D., *New Haven*

The Sesquicentennial of the Connecticut State Medical Society will be celebrated at Middletown in 1942. In anticipation of that event the *Journal* is publishing a series of historical papers on different phases of medical history in the eight counties of Connecticut. The following from the pen of Doctor Barker is the fifth in this series. (*The Editor.*)

PRIOR TO THE WAR for Independence there were but three schools of medicine in the American Colonies. A few of the fortunate ones studied at the Continental Universities, a few more went to Harvard, or Pennsylvania, or King's College, but for the great number medical education consisted of serving an apprenticeship with some physician and perhaps supplementing it with a course of lectures in an organized school.

At the time this chronicle begins there were, with one possible exception, no physicians in the New Haven Colony who held a degree in medicine. However, the profession was on a high plane and although it must be admitted that the scientific attainments of its members were not brilliant they were honest, conscientious gentlemen who practiced honestly and were constantly striving for better things. During the Revolution the doctors had been loyal to the Cause, many serving with the troops and while reviewing the war records one is impressed by the number of physicians who served as officers of the line.

With the close of the Revolution and subsequent adjustments came changes in medical practice. There were no restrictions on persons entering the profession and a large number of ex-surgeons-mates and field orderlies, who had learned a little of pukes and purges during the campaigns, set themselves up in practice. Realizing that the profession must protect itself the doctors of New Haven, led by Hubbard and Munson, determined to organize, issue licenses to practice, and establish the profession on stable lines.

After careful consideration and preliminary meetings, there appeared on the 10th, 17th and 24th of December, 1783, in the Connecticut Journal, the only paper then published in New Haven, the following advertisement:

"The Physicians and Surgeons in the County of New Haven are desired to meet in the Coffee House, in New Haven, on the first Monday of January next, at two o'clock P. M., in order to consult and form Regulations within the lines of

their profession of the utmost importance to the Public and themselves.

LEVERETT HUBBARD,
ENEAS MUNSON,
SAMUEL NISBIT,
LEVI IVES,
SAMUEL DARLING,
Physicians."

Following this and in accordance with the notice published in the Connecticut Journal, a group of physicians convened on January 5, 1784, at the Coffee House, which stood on the site of the present Post Office, and the New Haven County Medical Association came into being. It was the ninth medical society to be instituted in America. Of these nine societies there are but two others that survive to the present time—the Medical Society of New Jersey and the Massachusetts Medical Society. The New Jersey Society was non-existent between 1795 and 1807. It is, then, the pleasing distinction of the New Haven County Association to be the second oldest medical organization in America which has enjoyed continuous recorded existence since its founding. There are Associations within our own state that assert priority. The Litchfield County Association claiming 1764 as the year of its organization and the New London County dating from 1775. The evidence supporting these claims is not definite and no records have as yet been produced to substantiate them. The records of the New Haven County Association are complete and well preserved, a marvelous document covering the activities of the Association for one hundred and fifty-six years. To the student of local medical history the records of the County Association are a storehouse of marvelous information. The minutes of the meeting held January 5, 1784, are as legible as though they were written yesterday and record as follows:

"We, The Medical Practitioners of the County of New Haven, convened in consequence of an invitation, in the Connecticut Journal, from the Faculty of the Town of New Haven, on this fifth day of January, 1784, having made choice of Colonel Leverett Hubbard, Chairman, and Doctor

Samuel Darling, Secretary; do resolve ourselves into a Society to be called and known by the name of the Medical Society of New Haven County; plighting our Honor to each other for the strict observance of all such Regulations, as may be adopted by the majority of said society, formed for the following important purposes.

"1st, To lay a proper Foundation for the Unanimity and Friendship, which are essential to the Dignity and Usefulness of the Profession—

"2nd, To make accurate observations on the Air, Seasons, Climate, and the Various Diseases, incident to the Inhabitants of this County; with the mode of treatment and Event, in all singular cases—

"3rd, For the Communication of any Discoveries in Physic, Surgery, Botany or Chemistry—

"4th, For the purpose of a Correspondence with the Medical Societies in this, the neighboring States and Europe—

"5th, For the uniting with several Medical Societies within this State in a joint Application to the Legislature, praying them to adopt such measures for the future regulation of our Salutary Art, as shall effectually support and countenance Merit and discountenance, Ignorance and Presumption."

On the second of February following, the Association had its second meeting, and adopted, after mature deliberation, certain regulations which would "in time answer all the purposes of reducing the Medical Profession to a regular System, and prevent the world from the horrid Imposition of Quacks, Medicasters and Vain Pretenders, with which it is now infested."

Medical affairs progressed harmoniously. Somewhat awed by the Medical Society and more disappointed by the lack of financial return from their practice many pretenders withdrew to other fields, some entering political life, which at that time promised to be more lucrative than medicine and entailing far less labor. But the genuine physicians were constantly endeavoring to perfect their skill. On January 2, 1788, the Society voted: "That a collection of the most interesting cases that have been communicated to the Society be made, and that they be published in a pamphlet at the expense of the Society." This action was carried out, and at the meeting held on July 2 of the same year, there were distributed at one and eightpence per copy,

seventeen copies of the first volume of medical transactions published in this country.

The physicians at a very early date interested themselves in the study of vital statistics. In the minutes of the meeting at the Coffee House in New Haven on October 1, 1788, it is recorded that it was voted "that the Reverend, the Clergy of the County of New Haven be desired (by a publication in the papers) to give us quarterly a list of deaths in their several societies, with the disease." This compilation of vital statistics by the Association was continued for many years until it became a part of the activities of the civil health authorities.

During the period from 1784 to 1791, sixty-three physicians were satisfactorily examined for membership in the Association. Forty of them joined the Society at its institution, and twenty-three at later dates. One name has been erased from the record without explanation.

Leverett Hubbard continued in the office of president until 1792, when at his own request he was relieved of his duties and succeeded by Doctor Eneas Munson. Doctor Hubbard, or Colonel Hubbard as he was more often called, was a conspicuous figure. He was born in New Haven, July 21, 1725, and graduated from Yale College in 1744. It appears that while yet an undergraduate he studied medicine with his father, John Hubbard, a physician of high social position and great respectability, for he commenced the practice of medicine when but nineteen years old and served as a surgeon with the Louisburg Expedition during his twentieth year. Older doctors shook their heads incredulously at the young and inexperienced experimenter but this did not prevent his success. His courage and great energy, coupled with a pleasing personality, brought him a large practice and great respect and honor in other pursuits. He was prominent in the affairs of his church, and became a colonel of militia before the Revolution. During the war, however, his conduct excited grave suspicion and although he was doubtless a patriot he did not serve in the Army and during the occupation of New Haven by the British in July, 1779, he remained in town with the enemy. After the evacuation a town meeting appointed a trusty committee to inquire into the proceeding. The offender was summoned to appear and give reasons for his questionable conduct. The committee later reported that his reasons though "not fully sufficient" were to be viewed with "good will and candor" because of the circumstances.

In 1793 Doctor Hubbard was at the zenith of his career as the acknowledged leader of his profession. He had been elected the first president of the Connecticut Medical Society and had had conferred upon him by that Society the degree of Doctor of Medicine, the first to be so honored.

The next year, 1794, New Haven was smitten with a great and mortal epidemic. A disease described as "putrid sore throat" began in February and lasted until the middle of autumn. Early in June yellow fever appeared and continued until cold weather. Doctor Hubbard, much worn by the duties of his practice, left town and died from yellow fever in Hartford on October 1, 1794. He was buried there but soon after his body was secretly removed to New Haven. His will, dated February 19, 1790, disposed of an estate valued at over \$27,000.00, his books were valued at \$82.00, plate at \$150.00 and his stately dwelling on the west side of Meadow Street at the corner of Congress Avenue was valued at \$3,000.00.

Fifty years ago a brilliant medical biographer wrote "the qualities which distinguished Doctor Hubbard were not of the highest order, or the rarest among men; but he was famous in his day. He had a talent for business and tact in the management of the sick; amassed riches, lived in a fashionable house, and was greatly honored by his profession. In private life he was sober, just and exemplary; a good member of society, true to the church of which he was a member, compassionate, benevolent and faithful in the different relations of Life."

Hubbard shared his prominence in local medical affairs with Eneas Munson and when in 1791 he declined re-election to the presidency of the County Association, Munson succeeded him. Dr. Munson presented a personality distinctly different from his aggressive and dynamic predecessor. He was the son of Benjamin Munson, school master and mechanic and "man of wit" and was born in a small house on the westerly side of York Street, just south of Chapel Street, June 13, 1734. Three other children were born to his parents, but died at an early age of "black canker." Eneas, the only surviving child, was brought up tenderly and sent to Yale College, from which he was graduated in 1753, proposing to enter the ministry. During 1755 he officiated as chaplain to the troops of Lord Gardiner stationed on Long Island. Soon afterward, however, he abandoned his ecclesiastical career and com-

menced the study of medicine under the direction of Doctor James Darley of East Hampton, Long Island. It is generally believed that ill health caused him to give up preaching but an intimate biographer states that his instinct for wit and humor and his love for mirth sometimes got the better of his "solemn and dignified" endeavor, causing him to place the sacred and profane in irreverent juxtaposition and leading to many unseemly exhibitions. Numerous amusing anecdotes relating to his pulpit and other official performances were in circulation a generation ago. On one occasion he read all of the old notices which he found in the pulpit; on another, he rode off with a shirt he had borrowed of a brother minister to preach in, hotly pursued by its destitute owner, who wanted it for the afternoon service.

In 1760 Doctor Munson returned to New Haven and commenced practice at the southwesterly corner of York and Chapel Streets, in what has been described as "a permanent and very respectable establishment." He soon developed a large practice. Essentially a man of science he was always occupied with some experiment, particularly in medica materia and therapeutics. He became a botanist of some note and a chemist of no mean ability. There were peculiar traits in his make-up, he was superstitious and visionary, would not ride out in a thunder storm for fear of being struck by lightning and carried on nocturnal experiments in the transmutation of metals in which he implicitly believed. In 1794 he was given a doctorate in medicine by the Connecticut Medical Society and in 1813 was appointed to the chair of Materia Medica and Botany in the new Institute of Medicine in Yale.

Unlike his colleague Hubbard he sought no prominence in public life. During the Revolution he represented New Haven in the legislature and was active in the commission of the peace thereafter, but the theatre of his action was his profession and for seventy years he was an eminently respected practitioner of medicine. He practiced for the joy of it, it was no commercial venture to him; at the end of a frugal life his will disposed of an estate valued at but \$4,000.00.

"Through his long career of almost a century, when he had lived until no one remaining in his native city had survived so long, he found religion the staff of his age, as it had been the guide of his youth. His habitual trust in God through Christ

brightened as he advanced into the full glow of assured hope, and, although his last days were distressed by bodily suffering, his sun set with unclouded splendor, the cheering harbinger of a glorious morning." He died June 16, 1826.

It is said that some men are born secretaries and to this type must have belonged Samuel Darling, the first clerk of the New Haven County Association. He compiled the minutes of the first meeting and for ten years thereafter the chronicle of the affairs of the Association are set down in his bold handwriting, which is as clear as the day it was written. On the foundation so carefully laid by him the records have been accurately kept for one hundred and fifty years, there is not a page missing, the example set by the first clerk has been pridefully followed. It is no small debt that posterity owes to Samuel Darling.

His father, a graduate of Yale College and judge of the County Court, Samuel Darling, was born in Woodbridge, January 30, 1751. In 1769 he was graduated from Yale and a year later became the Rector of Hopkins Grammar School. Shortly after he began the study of medicine with Doctor Leverett Hubbard and apparently practiced for a time, but in August, 1786, he advertised his 'Drug Store in George Street near Colonel Leverett Hubbard.' Probably he entered the drug business to eke out a living while waiting for patients and at length contented himself with that pursuit. He did, however, give medical advice at his store, charging only for the medicine. He also bled those who called upon him, and drew teeth. His tooth-ache avenger is in the exhibit of the New Haven Colony Historical Society. It is a brutal, blood-curdling instrument.

Doctor Darling had little to do with the Association except to keep its record, reporting no cases, reading no papers, discussing no motions and serving on no committee except the Committee on Publication for the first transactions, a place for which he was admirably qualified. He was a conscientious and truthful man, eminently worthy and respected and esteemed by all. For purity of character, integrity of purpose, and kindly instincts he was extensively known.

With a review of his life and reading the records he so carefully kept for a decade, I am struck with a great desire to have known Samuel Darling, sterling gentleman that he was, cultured, student of literature, painstaking in all efforts, well versed in

the humanities. He died January 15, 1842, in his comfortable home on the west side of State Street, just below Chapel Street, and left a priceless monument to the Association between covers of a sturdy sheep-bound book.

On April 27, 1819, Nathan Smith was elected to membership in the Association. At that time Doctor Smith shared with John Warren a position of pre-eminence in the medical profession of New England. He came to New Haven in 1813, with a class of over thirty students in the New Haven Medical School in the building at the head of College Street, which had been erected for a hotel by James Hillhouse.

From the date of his election until the meeting of October 17, 1825, there is no mention of Doctor Smith in the records of the Association. He was probably fully occupied with other matters. He continued as professor of Theory and Practice of Medicine in Yale, was instrumental in founding the Medical School at Bowdoin College in 1821 and at the University of Vermont in 1820. During that year in July he performed the extraordinary operation of ovariectomy at Norwich, Vermont, which should in itself make his name famous but for the fact that McDowell in Kentucky had performed a similar operation in 1812, although of this Doctor Smith had no knowledge.

At the October meeting in 1825, Doctor Smith was appointed to present a disputation at the next meeting of the Association and from that date until his death he shared with Jonathan Knight the leadership of the Association. On April 17 he was elected to the presidency of the Association and continued in office until he died. At that same meeting he presented his paper on "Necrosis" which is now recognized as the classic description of osteomyelitis. On October 9, 1826, he presented "Some inquiries concerning the Comparative advantages of large doses of medicine administered at long intervals, and small doses frequently repeated." At the next meeting, April 16, 1827, he reported a case of reduction of a shoulder which had been luxated seven months. In October of the same year he read an address on "Temperature in Relation to Animal Life" and at the meeting on April 21, 1828, he reported a case, the title of which is not recorded.

In July, 1828, Doctor Smith was suddenly stricken ill with a malady which, although of short duration, left him weak and debilitated. He was unable to attend the meeting of October 20 and Doctor Jona-

than Knight, his staunch friend and biographer, was elected chairman pro tem. Throughout that fall and early winter he continued in enfeebled health. On January 13 he suffered a paralytic stroke and died at six o'clock in the morning of January 26, 1829, surrounded by his devoted family and ministered to by his distinguished pupils, Reuben D. Mussey of Dartmouth and George C. Shattuck of Boston. So passed from the field of its earthly labors the beautiful spirit of the man who had done most to establish medical education in America and the most distinguished physician New Haven has had.

About 1820 interest in the Medical Association waned and attendance fell off. On September 26 of that year it was voted "That by way of inducing members to attend more punctually, a dinner be provided at the annual meeting in April, and that all the members of the Society be considered as responsible for the bill."

Professional fees were given consideration from time to time but not until 1829 is there any record of the establishment of a definite fee table, and this only for physicians resident outside of the city of New Haven.

For ordinary visit—\$0.34
 Visit by night—\$0.84
 Consultation visit—\$1.00
 Mileage—\$0.17
 Ordinary cases of parturition—\$3.00
 Venesection—\$0.25
 Cathartic—\$0.17
 Emetic—\$0.17

These charges were apparently satisfactory for they were not revised until 1838, at which time the fee for ordinary visits was increased to \$0.50, night visits to \$1.00, consultation to \$2.00, and an additional fee of \$0.17 was added for extracting a tooth.

With the foundation of the medical school at Yale University the physicians became interested in the problem of medical education. It was their school and its affairs were close to the heart of every medical man in the community. In 1814 and continuing thereafter for many years, the County Association selected a young man to receive gratuitously a course of medical lectures at Yale. The success of the school was in the hands of these pioneers and they built well but not always harmoniously. One braver than the rest appeared before this Association in 1842 and delivered an address "on some of the

evils connected with the present system of medical education."

Many other problems of a public nature were given consideration. Because dependable drugs were not obtainable in the community, an Apothecaries Hall was established by members of the Society in 1820. The General Assembly of the State was petitioned to enact a law whereby the bodies of paupers and criminals would become available for anatomical study. During the period from 1849 to 1855, the records of the Society are largely concerned with the sale of nostrums, one member being vigorously censured for purveying "Myers Extract of Rock-Rose and Sarsaparilla."

Such were the men who present themselves for our considerate and affectionate review, such is a glimpse of the environment and limitations in which the splendid background of the New Haven County Association is set. One entertaining biographer of the physicians of that early day says, "For myself I feel as much reverence for pioneer work as for perfected work and for infant steps as for the prance of the war-horse." It is easy to picture with what seriousness, what anticipations, what fidelity and what love for each other they came together periodically for their meetings. On horseback they came, some the day before, prepared with their best and most puzzling cases, it was a great counsel, a period of communion, a social occasion. Gathering in groups in that magic place, the tavern tap-room, these sturdy fellows strived consistently to improve the standards of medical practice. There were few vicissitudes, little friction, and they went about their self-appointed task with a steadfastness of purpose and seriousness of endeavor that is delightful and glorious to review.

New Haven's Health Record for 1940

The City of New Haven recorded but three deaths from both major and minor communicable diseases during 1940, one each from typhus fever, trichinosis, and whooping cough. During the year there was a complete absence of infantile paralysis, epidemic meningitis, encephalitis, epidemic measles, and complications in reported cases of scarlet fever. Pneumonia deaths were reduced by one-half and tuberculosis deaths by about one-third. Automobile deaths and deaths from suicide increased materially.

ASPECTS OF THE NARCOTIC PROBLEM

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OPIMUM, including its derivatives—morphine, codeine, heroin, etc.—has long been regarded as the one most valuable drug in the possession of the medical profession. However, along with its most important properties in the relief of pain, spasm nervous shock and mental distress, it has, down through the ages, also been used for its exhilarating, stimulating mental effect, for the production of pleasure and release from the realities of life. Habit-forming, the user soon becomes its slave and the demand may become insatiable. Attempts by governments to regulate the supply and to control the demand, have always been beset with many difficulties and have been accompanied by a tremendous bootlegging industry with all its criminal features.

International coöperation in an attempt to suppress the illicit traffic in narcotics has reached the point where the existing treaties supervise every stage in the handling of narcotic drugs from the manufacturer to the consumer. However, there has been no means of limiting or controlling the production of the raw opium itself and the problem of drug addiction has not been solved. So, at the two extremes, first the absence of international regulations in regard to the production of raw opium, and the other, the continuous craving and demand for the drug by addicts, still hampers all efforts for solution of the problem of international control and permits an illicit traffic in drugs, an evil whose extent is hard to estimate.

It has been a long up-hill fight in the United States to bring the control of the drug traffic to its present state of efficiency and most of us little realize the effort which has gone into the solution of this problem. The Bureau of Narcotics under the Treasury Department of the United States Government has waged ceaseless warfare against narcotics for many years. The lax and diversified state laws made effective control of the drugs almost impossible. The Harrison Narcotic Law was enacted for revenue only and had no effect on the addiction problem. Efforts for a narcotic law fundamentally uniform in each of the states were sponsored in

1932 by the American Medical Association Committee on National Legislation of which our own Doctor D. Chester Brown of Danbury was Chairman. At the 141st annual meeting of the Connecticut State Medical Society,¹ a committee was appointed “for the study of drug addiction with special reference to Connecticut.” After three years of questionnaires, correspondence, consultation and study, and with the close coöperation of the Federal authorities and the State Board of Health, a bill was presented to the Connecticut State Legislature in the spring of 1935 and was adopted. Similar uniform narcotic laws have now been adopted by all but four or five of the states.

The section which provides for enforcement reads as follows: ‘Sec. 988c. Enforcement and Coöperation. The state department of health, the commissioners of pharmacy, the county health officers in their respective counties, the authorized agents of such officials and the police authorities and police officers in their respective jurisdictions, and all state’s attorneys, shall enforce all provisions of this chapter, except those specifically delegated, and shall coöperate with all agencies charged with the enforcement of the laws of the United States, of this state, and of all other states, relating to narcotic drugs.’ Under this law which promotes such close coöperation with all the various law enforcement agencies, the State Department of Health set up an organization in the Bureau of Preventive Diseases and a narcotic agent was appointed who began his duties early in 1935. During the past five years, he has been active in the enforcement and the provision of the Act.

TABLE I

	NO. NAR. CASES HANDLED	CASES REFERRED TO FED. BUREAU
1937	28	8
1938	40	20
1939	48	16

The above table shows the number of new narcotic cases handled by the Department during each of the last three years. According to the Federal Narcotic Bureau,⁶ in 1938, Connecticut had only 251 narcotic addicts, a rate of 1.33 per 10,000, slightly less than the average of 1.53 throughout the

Presented at Staff Meeting of the Waterbury Hospital, May 27, 1940

country. The rate varies from 10.09 in Nevada to 0.52 in Indiana. So, in Connecticut this problem seems to be well under control and the law being administered efficiently.

The Federal Narcotic Bureau⁶ is still constantly at work in carrying out the machinery of regulation of narcotics within the country and attempting to control illicit importation or smuggling across the borders. Attempts are continually being made to get opium, heroin, and morphine into the country and all sorts of ingenious devices and methods are used. The tins of raw opium weighing about five taels, less than one pound, are each worth from \$120 to \$400 in the various cities of the United States and offer a great temptation to smugglers. During the past eight years the seizures of opium have varied from 970 to 5,500 pounds per year (in 1938, 1,720 pounds were taken). The convictions for violation of the Narcotic Law range from 2,450 to 3,128 per year (2,531 in 1938) which gives some idea of the activity of the enforcement officers. Another feature of the work of the Bureau of Narcotics is an investigation being carried out under the auspices of the National Research Council of non-habit-forming analgesics which may be used as substitutes for opium. The great majority of narcotic addicts and violators are criminals. A study shows that of about twenty thousand persons in the Federal prisons, 2,200 or about ten per cent are Narcotic Act violators. Also, in a series of narcotic addicts studied, the overwhelming majority had criminal records preceding drug addiction by eight or ten years.

In his chapter on the problem on narcotic addiction in the book, "Here's to Crime" Mr. Riley Cooper⁸ gives a graphic picture of the relation of the drugs to crime and criminals. Conditions as pictured then, in 1937, have been greatly helped by the Uniform Narcotic Laws which now provide for more coöperation between Federal and local law enforcement agents. The dangers of marihuana are pictured rather vividly but that seems to be also under control at present. Mr. Rivard, the narcotic agent for Connecticut, says that it is not a problem in this state.

The world situation is quite different. China has been the center of the opium supply of the world for many years. It was first brought to international attention in the middle of the last century when her rulers, in trying to prevent shipments of opium from India, were forced by England in the Opium Wars to open her ports to importing. In spite of her own

enormous production, she has continued to import opium from Turkey, India and Iran. In 1922-23,² it is estimated that 15,000 tons of opium were produced in China—90% of the world's crop; 300 tons of opium being estimated as enough to supply the world's annual scientific and medicinal need for the drug.

The problem why there is such an appetite for opium has not been solved. Craving for the drug is partly due to the conditions under which the average Chinese lives, the lack of education and ambition, entertainment, the low standard of living of the mass of the population, the escape from reality and the temporary pleasure of the drug; also, perhaps, the belief that opium is an aphrodisiac and aids in the procreation of progeny.

The Oriental attitude¹¹ towards opium smoking and opium addiction may be compared with our own attitude towards the use of alcohol, just as we distinguish between the alcohol users and the addicts or inebriates. Much of the opium smoking is social and not a serious problem and may account for some of the apathy against its prohibition. It is the addicts and particularly those who use morphine and heroin who are the problem—heroin especially is deadly.

Addiction is easily formed and spreads rapidly. Estimates four years ago on the extent of drug addiction were that fifteen to fifty million Chinese were addicts and since the Japanese invasion in 1937, it has been growing.

In 1906, the Imperial government attempted to stamp out poppy cultivation. Conditions were at their worst and it was estimated that 30-40% of the population were affected. At this time they secured the coöperation of England to the extent of limiting the import of opium proportionately to the Chinese government's willingness to limit the growth of the poppy in China. By 1914, Indian import was stopped and in China opium had been suppressed to a great extent. However, the chaotic political conditions during the next ten years caused a recrudescence in poppy cultivation. This was encouraged and enforced by certain provincial military governors for the purpose of taxation and revenue for their local armies.

At the 1924 meeting of the Opium Advisory Committee of the League of Nations,² the situation seemed entirely out of hand. The Committee's recommendations were all rejected as it was felt

China was in no position to suppress the production or smuggling of opium or to control or register the consumers. However, in 1931, China again joined in the movement and in 1934 adopted a radical program of control by creating an opium suppression bureau directly responsible to the president of the military council. This was headed by General Chiang Kai-Shek himself. There were two parts to the program: 1, the regulation and suppression of the cultivation of the poppy in certain provinces and campaigns against the use of the drug; and 2, bureaus for registration of addicts and regulation of sale, reserving for the government any profits from such administration. A series of laws and regulations were drawn up including capital punishment for failure to coöperate. In the portions of the country under Nanking, real progress was made. The greatest difficulty was in the outlying and more or less independent provinces and in the areas under the protection of foreign countries with their extra-territorial privileges. The six-year program undertaken was to end in 1940 and was well under way when the present invasion by the Japanese in the summer of 1937 occurred. Since then, the campaign has slowed up but has not collapsed.

According to Mr. Amleto Vespa,⁴ an Italian of the Japanese Secret Service in Manchuria, Japan must take the responsibility for the great share in this illicit opium traffic. When Japan took over Manchuria in 1931, she created a traffic in narcotics which has grown to tremendous proportions. The League of Nations' report on narcotics contrasting the state of affairs prevailing before and after the Japanese occupation of Manchuria paints an alarming picture of how that territory has been turned, as a result of Japan's deliberate policy, into a source of supply of deadly narcotics for the entire human race. Under the Japanese Narcotic Monopoly farmers were instructed to grow poppies instead of soy beans, and under the protection of the Japanese Army, the production of opium has reached such proportions that the Japanese export millions of dollars worth to China every year and it is a settled part of Japanese technique of conquest to drug its subject as soon as possible for drug addicts soon lose every thought of resistance.

Labelled as "Japanese Military Supplies" opium was shipped on Japanese boats to all ports in China. They were addressed to the Japanese military command wherever there was one, and if there was no military command, the opium was addressed to the

Japanese consulate. Japanese warships transported opium along the Chinese coast and Japanese gunboats performed the same service along all the large rivers in China.

In Darien, Mukden, Harbin, Kirin, Tientsin and other cities the Japanese have factories where they manufacture morphine, heroin, and other narcotic drugs, production amounting to many hundreds of millions of dollars every year.

Edgar Snow,⁵ writing in the *Saturday Evening Post*, February 1934, describing the drug traffic in Manchuria stated that the monopoly had vastly stimulated both production and consumption and he claimed that at least twenty per cent of the Japanese and Korean subjects in Manchoukuo were directly involved in narcotic trade. (Others say thirty to fifty per cent.) To kill people with bullets and shells costs money but to kill them with drugs and also reap a large profit is not only good business but also brilliant military strategy. In Harbin⁶ in the seven months from January to July, 1937, of 1,793 unclaimed corpses picked up in the streets and alleys of that city, 1,485 had died as a result of narcotic addiction. Japan is sending narcotics to both North and South America, to the Phillipines, and to all the South Sea Islands.

While it is Japan's policy to corrupt the rest of the world, it forbids its own nationals in China and Manchuria from using habit-forming drugs and patronizing gambling houses on the penalty of being deported to Japan or heavy prison sentences. Japanese military regulations³ state "Paragraph 15: The use of narcotics is unworthy of a superior race like the Japanese. Only inferior races, races that are decadent like the Chinese, the Europeans, and the East Indians, are addicted to the use of narcotics. This is why they are destined to become our servants and eventually disappear. A Japanese soldier who is guilty of using narcotics becomes unworthy of wearing the uniform of the Imperial Japanese Army and of venerating our divine Emperor." In spite of this, many of the Japanese army officers have fallen victims to the drug habit causing considerable alarm to military powers.

Mr. T. Z. Ku,⁷ now in this country engaged in student relief work and a Chinese delegate to the League of Nations Opium Conference, states that Japan's three point program for the subjugation of the Chinese is Drugs, Prostitution, and Gambling, and that the areas occupied by Japanese during the

present invasion had been flooded with drugs, heroin, and morphine. From twenty to thirty per cent of the population of Nanking is said to be using drugs; these figures are apparently confirmed by American and British observers, by reports of the League of Nations and by personal correspondence.

Lin Yutang¹⁰ in his novel, "Moment in Peking" which carries the story of the Yao family through recent history of China from the Boxer Rebellion to the present Japanese invasion, goes into the opium question in detail, quoting from the official reports and shows the effect of the narcotic traffic on the family and the official life of China. He charges the Japanese military authorities with using it deliberately to corrupt China mentally and physically in the areas under their control. Madame Chiang Kai-shek⁹ in her book, "This is Our China," published this year, shows also, the havoc and destructive effect of the opium traffic on China by the Japanese.

In the 1938 Bureau of Narcotics⁶ report of the United States Treasury Department, the commissioner goes into detail on the extensive commerce in narcotics in the various parts of China and concludes by stating that the "situation in parts of China under control of the Chinese National Government continues to give the effect of sincere effort with encouraging results. . . . In parts under Japanese control it is worse than ever and gives cause to the entire world for serious apprehension."

The fight against narcotics forms a part of the New Life movement which is identified with the larger expression of Chinese Nationalism—Reconstruction, Unity of action, and Concerted Resistance to further aggression by Japan. Belief by the Chinese that Japan is deliberately encouraging traffic in drugs for weakening the Chinese race has only increased hatred of Japan.

The future is not at all clear and probably depends on the outcome of the present world war and the Chinese struggle against the Japanese. If the Chinese are victorious in war, the odds are still tremendous for there exist powerful, wealthy, international

narcotic rings which have existed for years and are so hidden and protected by treaties that they can only be broken up by persistent and sincere coöperation of all the nations interested. If they lose, the prospect may well be alarming to the whole world.

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Thirteenth Anniversary Number of Harofe Haivri, the Hebrew Medical Journal

The thirteenth anniversary number of the *Hebrew Medical Journal* is dedicated to Professor Sigmund Freud. In the special issue of this semi-annual publication Doctor A. A. Brill presents a masterful exposition of "Freud's Metapsychology", and Doctor Philip Lehrman recounts much biographical detail and the story of Freud's earliest researches.

THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the \$37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

THE NEWER INSULINS

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The Author. PH.B., *Yale, 1918.* M.D., *Yale, 1921.*
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SINCE THE discovery of insulin twenty years ago efforts have been made to improve it, chiefly because its action was of too short duration. Severe cases of diabetes required two, three and occasionally even more injections each day in order to adequately control sugar metabolism. The recent discovery of protamine zinc insulin provided a long acting insulin generally requiring only one injection a day. More recently a third type of insulin, a crystalline compound, has become available. This insulin is at present designated and labeled as "an insulin specially prepared as Solution of Zinc-Insulin Crystals." It is referred to briefly as solution of zinc insulin crystals, crystalline insulin, or the crystalline type insulin. This is the purest insulin known and is especially indicated in instances of allergic sensitivity to insulin.

So that there are now three insulins available on the market: (1) the regular, unmodified, soluble, amorphous insulin, (2) the newer insoluble protamine zinc insulin, and (3) now the crystalline type of insulin. Regular insulin is still supplied in the usual strengths of 20, 40, 80, and 100 units per c.c., protamine zinc insulin is marketed as U-40 and U-80, and the crystalline type insulin at present is available as U-40 only.

Considerable confusion has existed in the past because of the several different strengths of insulin and now it has become even more complicated because of the increased number of insulins. Particular confusion exists between protamine zinc insulin and the crystalline compound because the latter is occasionally referred to also as crystalline zinc insulin. Protamine zinc insulin is not interchangeable with either the crystalline or regular insulin and care must be exercised to specify whether regular insulin, protamine zinc insulin, or the crystalline preparation of insulin is desired.

Earlier studies with crystalline insulin seemed to show that it had a prolonged effect over a period of

twelve hours or more and so was thought to fill the gap between regular insulin and protamine zinc insulin. However, according to more recent investigations at the Joslin and Mayo Clinics,¹ crystalline preparations of insulin as now available show the same rapidity of action as regular insulin with only a slightly more prolonged effect. Thus it appears that the crystalline type of insulin belongs in the same class with regular insulin as a rapidly acting insulin of short duration and the two insulins may be used interchangeably. Indeed, there no longer appears to be any need for the regular insulin since the crystalline type insulin is a superior insulin in purity, stability, and low allergic properties and is equally as effective as regular insulin, if not more so, in the diabetic at least.

Protamine zinc insulin remains the slowly acting and long lasting insulin of choice. It is still the insulin of choice in the routine care of diabetes because of its protective effect by making available a supply of insulin over a prolonged period of time. Where occupation and habits or the state of health is such that a twenty four hour period is too long to plan for in advance, or where protamine zinc insulin alone is thought to be insufficiently effective, or in acute diabetic situations, it has been found advantageous to administer a smaller dose of protamine zinc insulin as a basic insulin supply for its protective effect in conjunction with regular or crystalline insulin as required for the immediate needs.

The discovery of protamine insulin has not simplified the treatment of diabetes but it has improved it. With its continued use it is becoming increasingly evident that the requirements for diabetic control are undergoing a striking change. Apparent difficulties encountered with the use of protamine zinc insulin arise from efforts to seek laboratory end results comparable with those required of regular insulin in the past as criteria of diabetic control. There is growing conviction, however, that under protamine insulin therapy a sugar free urine all day long is not altogether essential nor desirable. Since the introduction of protamine insulin it had been noted that patients feel better when they show some

sugar in the urine and feel quite uneasy when sugar free.² Even conservative clinicians now permit glycosuria.³ Post prandial glycosuria is thought to be without harm.⁴ Furthermore, the frequency of normoglycemic glycosuria in the protamine cases⁵ may lead to insulin overdosage in any attempt to make the patient sugar free. Indeed, some glycosuria is now considered desirable with the use of protamine insulin as it affords protection from reactions. Ketosis, however, must be avoided and there must be maintenance of weight and freedom from symptoms as evidence of satisfactory treatment.⁶ Once again clinical judgment is paramount.

Protamine zinc insulin has shown an increased incidence of allergic sensitivity to insulin.^{7, 8} Some diabetics find protamine insulin difficult to use or cannot use it at all because of allergic skin manifestations. The crystalline type of insulin is less likely to cause sensitivity and is well tolerated in these cases except where sensitivity exists to the insulin molecule itself. Recently a modified protamine zinc insulin has been described which is practically non allergic.⁸ In this newer protamine insulin, the protamine is combined with a solution of zinc insulin crystals as a base instead of the amorphous insulin with zinc as in the commercial protamine zinc insulin. The modified preparation is a superior protamine zinc insulin retaining all the characteristics of the commercial product in appearance and effect with the added advantage of lower allergic properties. Diabetics sensitive to protamine zinc insulin have shown no sensitivity to this new protamine zinc insulin.*

Considerable investigative work on insulin is in progress and a number of insulin modifications have been reported upon experimentally. However, there still are only the two main types of insulin available commercially in this country; namely, (1) the rapidly acting insulin of short duration as represented by the regular and crystalline insulins, and (2) the slowly acting and long lasting protamine zinc insulin. With the increase in the number of insulins the diabetic is being increasingly exposed to the dangers attendant upon errors arising from interchange of the several insulins, their numerous

dilutions, and the various types of insulin syringes on the market. The problem is acute but the remedy is within reach.

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A.M.A.'s New Publication, "War Medicine"

Clad in a gory cloak of crimson *War Medicine* made its first appearance in January. It is to be a bimonthly journal published by the American Medical Association, "containing original contributions, news and abstracts of articles of military, naval and similar interest related to preparedness and war service."

Both the Division of Medical Sciences of the National Research Council and the House of Delegates of the American Medical Association have realized the desirability of a medium for recording such medical procedures as might be adopted in the plans for national defense, as well as the results of research projects under the control of the National Research Council and of information concerning problems of personnel. It is contemplated that future issues will contain official reports of special committees and records of the contributions of physicians to the nation's defense.

*This newer type of protamine zinc insulin is not yet available in this country but is being distributed by the Connaught Laboratories in Toronto, Canada. It is reported that these laboratories contemplate discontinuing the preparation of insulin in any form except that made from the crystals.

VOCATIONAL REHABILITATION OF THE DISABLED CONNECTICUT WORKER

E. P. CHESTER, *Hartford*

The Author, B.S., *Clark University, 1909. State Supervisor, Vocational Rehabilitation in Conn., 1930 to date*

THE PROGRAM of Vocational Rehabilitation, while humanitarian in many aspects, was originally planned for the injured worker to supplement the services of Workmen's Compensation by offering him a chance to provide himself a set of new skills that would have value in the employment market. The enactment by Congress of the Civilian Rehabilitation Act in 1920, following the Soldier Rehabilitation Act of 1917, provided for re-establishment in industry of persons injured in industry "or otherwise"—thereby opening the door for service to persons disabled by other causes. This so call "otherwise" group now consists of persons with disabilities incurred as the result of public or other type of non-industrial accident or as the result of disease or birth injury.

This national program of Vocational Rehabilitation was planned as a coöperative undertaking between the Federal government and the States and funds were provided by the Federal Act to participative states on the basis that for every dollar of federal funds there must be a like expenditure of state money. In Connecticut as in most states the administration of the program is vested in the State Board of Education. Connecticut's annual allotment of federal funds is approximately \$40,000.00.

Who is eligible for vocational rehabilitation in Connecticut? Any person who is a citizen and a resident of the state, who is 16 years of age or older, and who has incurred a permanent physical disability and is thereby handicapped in following his usual occupation, is considered eligible. There may be, however, conditions surrounding a disabled person, either connected with the disability or not, which would make it difficult to recommend the particular worker to a potential employer. For instance, persons disabled by epilepsy, certain nervous disorders, or those possessing undesirable personal habits and characteristics may meet the requirements of eligibility, but not feasibility.

The selection of disabled persons for rehabilitation service is based upon the medical findings of the doctor. It may also require searching inquiry

and investigation of many details such as interests, aptitudes, educational attainments, experience, habits, personality and other traits. After all the data concerning a disabled person is assembled and studied, a rehabilitation diagnosis is made on the basis of which a plan of rehabilitation is prepared.

This plan forms the basis of a series of services, including placement, that may be required by an individual to render him vocationally fit to engage in a remunerative occupation. The rehabilitation plan may involve physical restoration as well as vocational preparation. Vocational rehabilitation funds can be used for the latter purpose—but not for the former. To accomplish the physical restoration required before a vocational program can be started, it is necessary to make arrangements with coöperating agencies. Indeed, the coöperation of many agencies must be secured in the successful conduct of a program of vocational rehabilitation. Agreements of coöperation have been made with such state agencies as Workmen's Compensation, State Employment Service, Division of Crippled Children of the State Health Department, the State Board of Education of the Blind and the State Tuberculosis Commission.

In addition, working relationships have been established with many other agencies throughout the state such as the Connecticut Society for Crippled Children, the Schools for the Deaf, the National Youth Administration, the Adult Guidance Service, Public and Private Welfare Agencies, etc. The coöperative agreement with one of these agencies has resulted in the accomplishment of an outstanding piece of work. I refer to the State Tuberculosis Commission with which agency in March, 1938, a special arrangement was made to improve and expand rehabilitation service to the tuberculous.

In Connecticut, as in any state, the Vocational Rehabilitation Service and five other distinctly different yet closely related agencies must function as a unit in developing a plan of action as regards the disabled worker. These five agencies are the Doctor, the Compensation Commissioner, the Insurance Company, Organized Labor and the Employer.

Some service of each one of the agencies men-

tioned is essential or valuable to the other. Rehabilitation needs the advice of the doctor in determining physical phases of eligibility and feasibility, in making plans for a program of physical restoration, and in determining work limitations of disabled persons.

In turn the doctor may seek the advice of Rehabilitation in determining the effect a planned surgical procedure may have on the vocational adjustment of the disabled worker.

The rehabilitation program would be useless without the coöperation of the employer, and employers have been known to seek the advice of Rehabilitation in handling the vocational adjustments of some injured workers. And so the unity of opportunity for serving the disabled worker grows more apparent as the various points of contact are studied.

What of the attitude of the employer toward the employment of disabled workers? In general employers in our state are willing to consider the employment of capable handicapped persons on the basis of ability to do the job.

As industrial conditions change, so usually change the problems of the handicapped worker. Age in itself has been considered a severe handicap in industry. Many studies have been made of the "man over 40". Add a substantial physical defect to age, and the problem of making a living becomes a tough one.

Industry has lately been giving increased attention to the employment problem of the older worker, whether disabled or not, in view of the fact that our population is gradually aging, and as time goes on it will be necessary for industry to operate with a larger percentage of older workers or help pay the cost of maintaining them in idleness. Doctor and employer must combine medical science with mechanical genius to develop a plan for the productive use of those extra years added to the worker's span of life.

The National Defense Program would appear to increase the need for a closer study of the older worker's problem. Our Connecticut Rehabilitation Service has for some time been promoting the idea of utilizing physically handicapped persons in the Defense Program, and has been training and placing such persons in suitable defense jobs.

Since the program of Vocational Rehabilitation began in Connecticut 10 years ago—nearly 550 persons have been prepared for and placed in suitable

employment. During this period, the only state worker in this field has been the supervisor. Studies made of the small but important group would indicate that the wages earned in any one year by the group, over and above all income at the time of contact with the Rehabilitation Service, were approximately 300% greater than the entire cost of operating the program during each preceding year. It would thus appear that society is receiving annually a 300% dividend on its investment in rehabilitation.

New Editor in South Carolina

The South Carolina Medical Association has elected Doctor Joseph I. Waring of Charleston editor of the state medical journal to succeed the late Doctor Edgar A. Hines. Doctor Waring has been one of the associate editors for some time so that the new responsibility which has fallen upon him will not be entirely unfamiliar.

One Better Than the Country Doctor

Doctor Fishbein, Editor of the Journal of the American Medical Association, contributes the following colloquy between his daughter and the census taker.

Census Taker. What does your husband do?

Answer. He's an assistant surgeon in the clinic.

C. T. How many hours does he work each week?

A. He works all the time.

C. T. Oh! No! You don't understand what I mean. How many hours does he work?

A. He works all the time!

C. T. I don't understand.

A. He gets up at six. They operate until two. Then he sees patients. Then he goes to the laboratory. After dinner he works in the library or goes to conference. After that until six in the morning he's on call.

C. T. But he can't do that! The law says he can only work forty hours.

A. I'm sorry! He works all the time.

C. T. Well, I'll look up the special classifications. You see here the biggest classification of all is for a country doctor. He can work sixty hours a week.

A. I'm sorry My husband works all the time.

C. T. Well. I'll send in a report. I guess they'll make another classification.

AMELANOTIC MELANOMA

Case Report

The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the JOURNAL. The following from the Waterbury General Hospital is the fourth in the series. (The Editor.)

A 51 YEAR OLD white married Canadian fireman was admitted with the chief complaint of mass in the right groin, which he had known for about two weeks. He dated the present illness from a blow on the right leg caused by a slash bar, which caused a bit of pain, but soon disappeared. About one and one-half days after he noted a swelling in his right leg, just below the groin. He noted that this was somewhat bluish and was not tender to touch. The mass had grown somewhat in size since its discovery. He never had anything similar to this. Past illnesses and family history were non contributory, except for an ulcer on the dorsum of the second right toe which failed to heal and which was excised fifteen years before this admission.

Physical examination revealed a well developed and well nourished white man who was in no acute distress. Temperature was 98 (p.o.), pulse—72, respiration—20, blood pressure 140/80, head symmetrical, hair sparse, eyes normal, ears normal, teeth had many fillings, several absent, tonsils small. Neck showed no adenopathy, tenderness or asymmetry. Chest symmetrical, with equal expansions and no bony deformity. Lungs normal to percussion and fremitus. "Clicking" rales were heard at left base posteriorly and breath sounds vesicular at the periphery. Heart slow, normal rate and rhythm, sounds fair quality. Heart not enlarged to percussion and no murmurs heard. A_2 was greater than P_2 . Examination of the abdomen revealed no masses, tenderness or scars. The genito-urinary system was negative to inspection. Reflexes equal and fairly active. Below the right groin there was a mass about the size of a pigeon's egg, freely movable, firm and non tender. No impulse to coughing and no bony abnormalities.

Two urine examinations showed no abnormalities and two blood counts were not abnormal. Blood chemistry showed sugar 105.2 mgm.%; N. P. N. 31.5 mgm.%; and uric acid 3.7 mgm.%.

On the second hospital day, under infiltration anesthesia, the record states, "A vertical incision was made over the femoral mass. Subcutaneous tissue was dissected down to the mass which was found to

be well circumscribed. What appeared to be a sac was opened, and a large amount of very friable fatty material crumbled out. Whether this was the omentum or whether it was a mass of necrotic glands with a possible malignant degeneration, I am unable to say. The entire mass was dissected out, and a deep closure of the femoral ring was made with three chromic sutures." The hospital course was uneventful and the patient was discharged healed on the 9th postoperative day.

Second Admission (21½ months later).

The patient sought readmission because of an area of erythema occurring on the right foot for about one week. The area was of about the size of a dime when first noted, but was about three inches in diameter on admission. There had been a moderate amount of pain in this area. There had been no chills or fever, or no pain in the inguinal nodes. (No note was entered as to the patient's condition in the interim.) The physical examination showed temperature 99.8 (r); pulse 80; respiration 28; blood pressure 140/80. Physical examination was essentially similar to that on the previous admission, except for that of the right leg, which had a firm circular mass which was two inches in diameter, and was located over the medial aspect of the femur, just above the knee. There was also a circular area of erythema over the mid portion of the right tibia, anteriorly. In this area fluctuation was present and considerable tenderness was present on deep palpation. An area of erythema was present over the right foot, just proximal to the toes. Admission urinalysis revealed one plus albumin, and few W. B. C. and occasional granular casts. Kahn test was negative. Blood examination showed R. B. C. to be 4,300,000 with 80% hemoglobin—6,800 W. B. C. with PMN 70%—small lymphs. 20—large lymphs. 2—mono. 4—eosinophiles 4.

After wet dressings were applied, the areas of erythema on foot and thigh were incised the day after admission. Much pus was obtained, from which the laboratory grew *S. aureus*. After this the patient had low-grade fever for a week, with afternoon excursions to 101.6 or lower. The pulse was un-

changed. On the thirteenth hospital day, after one afebrile week, the mass on the lower thigh was excised. The operator made the following note: "Straight incision in back of right lower thigh, over the site of the tumor mass. Tumor was dissected carefully. Large vessels were seen to enter. These were ligated. The mass extended down to the medial sheath. During the process of removal, broken down material seemed to ooze from the mass." Two days after this procedure, the patient complained of epigastric pain, with the vital signs all normal. On the fifth postoperative day, the temperature rose to 102.2 (p.o.). Two days after this, after an examiner had noted tenderness in the epigastrium, without enlarged liver or masses being felt, an intravenous cholecystography was reported as follows: "Gall bladder visualized fairly well seventeen hours after intravenous gall bladder dye. Density is slightly irregular. No definite evidence of gall stones is made out. Smooth outline 3.7 x 9 cm. Contracted down fairly well after fatty meal." An x-ray of the chest three days after this was reported as follows: "Right side of the diaphragm smooth, angles and apices are clear. The left side of the diaphragm is partly clouded. The heart shadow is large. Cardiac chest ratio is 16.5 cm. to 29 cm. Hilus shadows are dense. Lung fields clear. Impression—Large heart." For several days after the intravenous cholecystography, the patient ran a gradually declining fever—maximum 102 and normal in six days. The next day, an examiner noted that the patient's complaints referable to his epigastrium had been more pronounced. There was more tenderness in his epigastrium. His temperature rose to 103.4 (r), his pulse accelerated to 96. He continued to have a febrile course, between normal and 104.4 (r), and after four days of fever, which was then declining, he was given sulfapyridine and it fell to normal in two days. A blood count on the day before this was administered showed 78% hemoglobin; 3,620,000 R.B.C., 13,400 W.B.C., with PMN 82% and lymphs 18%. One examiner thought that this fever was caused by pneumonia, but this was never proved. After another afebrile week, he again had fever, and complained of pain in the right chest, which was relieved by strapping. His fever subsided without additional medication, and he was discharged on the 49th hospital day.

Third Admission (1½ months later).

The patient had been fairly well until two days before admission, when he began to experience

severe right upper quadrant abdominal pain and vomiting of bile stained material, both of which were worse after eating. Very little food had been retained. Physical examination was reported essentially as previously, with temperature 103.2; pulse 90, and blood pressure 220/120. The liver was enlarged two to three finger breadths, the spleen was not felt. There was slight tenderness in the right upper quadrant of the abdomen, but none in the costovertebral angles. There was slight pretibial edema of the right leg. After three days of fever, a medical consultant felt that he had consolidation of the right lower lobe. An x-ray of the chest did not confirm this, but mentioned that he had a wide mediastinum measuring 9 cm. However, he was given sulfapyridine and he became afebrile in three days. Repeated x-ray studies of the chest revealed congestion of the left lower lobe, left ventricular hypertrophy and aortitis. A gastro-intestinal series was negative. An electrocardiogram showed inversion of the T waves in leads 1 and 4: QRS spread and notched in leads 1 and 4 and left axis deviation. This was diagnosed as caused by coronary disease. During the rest of his hospital stay, his temperature rose to 102 and lower. The blood examinations showed only gradually increasing anemia, and he was discharged on the 27th hospital day.

Final Admission (5½ months later).

Ten days before the final admission, a small mass was removed from the superficial tissues of the left upper quadrant of the abdomen. A few days before admission he went to the dispensary, complaining of spitting blood. Examination revealed a tumor of the right tonsil. The patient complained of weight loss and weakness. He was seen in the tumor clinic, where removal of the tumor and tonsil was advised. Admission examination revealed normal temperature, pulse and respirations. The blood pressure was not recorded. There was some percussion dullness at the right base posteriorly, where some dry, crackling rales were heard. The liver was questionably enlarged (? nodular). There was some tenderness in the epigastrium. The tonsillar tumor was described as the size of a walnut, ulcerated, and pedunculated. On the fifth hospital day, the tumor and tonsil were removed uneventfully. The next day, his temperature abruptly rose to 105, his pulse to 100, he complained of pain in the right chest, and a chest film showed congestion of the right lower lobe. An examiner reported that there were rales at both bases. The next day his pulse was very rapid and

irregular, going to 200 beats per minute at times. He developed hicough, and a leucocytosis. His abdomen was reported as soft and non tender, and despite supportive treatment, with fever persisting, he died three days after removal of the tonsillar tumor. A blood culture was reported negative.

DISCUSSION AND DIFFERENTIAL DIAGNOSIS

Dr. O. J. Bizzozero: In order to make a diagnosis of this case, we must connect three things. (1) The development of a mass in the right groin. (2) Development of hypertension. (3) A development of a mass in the right tonsil—which resulted in death.

It is only logical that we should start with the presenting symptoms—mass in the right groin. This mass no doubt represents glandular enlargement of the deep femoral lymph nodes. The solution of the whole problem lies in the enlargement of these glands. These glands drain the integument of the lower extremity, the skin of the scrotum and penis, and the area around the anus. The enlargement of these glands can be due to infection or to a new growth. Nowhere in the history have we found any question of infection occurring in the area mentioned above. Therefore, there is no doubt, hardness of the glands plus the material evacuated from them, points towards a new growth as causative factor.

These glands to be involved by a new growth can be involved in three ways: 1. By the new growth developing within the gland themselves, such as, Hodgkin's or Endothelioma. But this is not a usual site for this type of tumor to develop. This group of tumor usually affects the glands in the cervical region. 2. These glands can become involved through drainage of the efferent lymph vessels and since this man had an ulcer removed from his toe 15 years ago, this must be considered as one of the possible sites. Most common tumor which would fulfill this history would be one of the melanoma group which are very prone to occur on the extremity and can extend or metastasize years afterward. 3. These glands can be involved by retrograde extension from the efferent lymph vessels. There is no doubt that everyone accepts the theory of retrograde extension of tumors. If this be the case, we know that the deep femoral nodes empty into the aortic and lymph nodes, which in turn drain the kidneys and adrenals. Therefore, it is perfectly possible that a tumor could start somewhere in the kidney, adrenal area, by retrograde extension reach the deep femoral node. And then again, the aortic

nodes finally drain into the mediastinum and eventually could reach the tonsil on that side. This explanation could perhaps explain all the symptoms as given by this man. I admit the explanation is not a natural one and I would much rather explain this on the basis of direct extension. However, this explanation accounts for the appearance of the mass, the color of the mass and the extension of the mass to the tonsil. The development of the hypertension could be explained by two possibilities. 1. If this were primary adrenal tumor it would naturally give hypertension. 2. If the adrenal were large enough it could interfere with the circulation with either one of the kidneys and cause a so called "Goldblatt" kidney.

I would much rather go back and explain all the circumstances being related to the tumor of the toe fifteen years ago. In that case, the spread would be of a natural spread from toe to femoral—to aortic—to adrenal—to tonsil. We could explain the hypertension as due to interference of circulation to the kidneys because of an enlarged adrenal. Finally the appearance of the node on the left side of the abdomen must be explained. We must remember one fact, that usually, if one adrenal is involved by tumor the other is also frequently involved by extension and in this case we may have an involvement of the adrenal on the left side and with spread of the tumor to the left side of the abdomen.

DR. BIZZOZERO'S DIAGNOSIS

1. Probable melanoma of toe.
2. Bilateral Adrenal Tumor.
3. Goldblatt Kidney.

DIAGNOSIS OF SURGICAL SERVICE

Melanoma of toe, surgically absent, with multiple metastases.

ANATOMICAL DIAGNOSES

1. Healed surgical scars of right second toe; right popliteal space; right groin and left abdominal wall.
2. Bilateral adrenal mesoblastoma with metastases to omentum, heart, mediastinum.
3. Hypertensive and arteriosclerotic heart disease with congestive heart failure.
4. General arteriosclerosis.
5. Nutmeg liver.
6. Cyanotic induration of spleen.

MICROSCOPIC DIAGNOSES

1. Amelanotic Melanoma, metastatic to inguinal glands; skin; heart; omentum; mediastinum and adrenals, arising from a primary lesion of the toe surgically removed seventeen years before death.

PATHOLOGIC DISCUSSION

Dr. Joseph O. Collins: The nodules removed from the groin at the first admission to this hospital proved to be very cellular new growth, made up chiefly of spindle shaped cells, but including groups of polyhedral cells resembling epithelium. No pigment was found but the picture was that of amelanotic melanoma, metastatic. After receiving the pathology report, the interne on service made a very thorough search of the leg and foot for a primary tumor. All he found was a tiny, almost imperceptible scar on the dorsum of the second toe. Upon questioning, the patient remembered that a small sore which failed to respond to local applications had been removed from this toe at another hospital, fifteen years before. Review of this section revealed a non-pigmented mole with malignant transformation. There was superficial ulceration, and in the floor of the ulcer were nests of epithelioid cells of variable size and shape and staining, some of which contained nuclei in mitoses. Similar nests of cells were found in the dermis adjoining the ulcer and in the rete pegs of the adjacent skin.

At autopsy the only skin nodule found was a recurrence in the scar in the right popliteal space. Before opening the body a mass could be felt in the left upper quadrant. I have here (demonstrating) the two kidneys, surmounted by these tremendous tumor masses which have largely replaced the adrenals. This larger mass is in the left adrenal. It measures 15 cm. in diameter. It lay anterior to the upper pole of the kidney, while the lower pole was just visible beneath it. The kidney was displaced downward and the renal artery was compressed between the tumor mass and the vertebral column. This might very well satisfy the requirements of a "Goldblatt kidney" if such a lesion is necessary to explain the hypertension which developed toward the end of the illness. The tumor is firmly fixed to the capsule of the kidney, but there are no adhesions between the capsule and the kidney cortex, so that after stripping the capsule, the kidney separates readily from the tumor mass. On gross section, the tumor presents a soft, yellowish-pink cut surface of an encephaloid character, scattered over which are

a few small, purplish, hemorrhagic, partially necrotic areas. This smaller mass (demonstrating) replaces the right adrenal and measures 11 cm. across. It is similar to the mass on the left except that it is softer, more hemorrhagic and more nodular. The only other tumors found grossly at autopsy were a few tiny soft white nodules in the omentum, and one in the mediastinal fat, and one in the right ventricle just beneath the endocardium.

After completing the autopsy we were doubtful if the adrenal and abdominal tumors were related to the original skin tumor, because they seemed to be of a much softer consistence. However, here are the sections (projected on screen) of the first tumors removed from the groin, that removed from the tonsil, and the adrenal tumors. They are all identical, being composed of spindle-shaped and polyhedral cells, with round or oval nuclei and acidophilic cytoplasm. The cells are chaotically thrown together in broad sheets and alveolar groups, supported by a delicate connective tissue stroma. No pigment is found except what I take to be blood pigment. It gives a positive Prussian blue reaction. The dopa reaction was not done.

In summary, we have a non pigmented mole removed in 1923, with metastases first manifesting themselves fifteen years later in 1938. Metastatic nodules were not numerous, but were widely disseminated to skin, tonsil, heart, mediastinum, omentum and adrenals. The adrenal lesions were immense. Had there not been available a section of the original lesion of the toe, the primary tumor might easily have been lost sight of in the fifteen year interval, since its nature had not been recognized at the time of the first operation. In that event, this would have been recorded as another so called primary melanoma of the adrenal gland.

In addition to the neoplasm, there was generalized arteriosclerosis and cardiac hypertrophy. The heart weighed 480 gms. Hypertrophy was limited to the left ventricle. The coronary vessels were calcified and there was patchy fibrosis throughout the left ventricle. The liver was large and showed a marked degree of nutmeg mottling of chronic passive congestion, as well as acute congestion. There was marked venous engorgement, congestion of the lungs, and moderate ascites and pleural effusion. These findings were interpreted as evidence of terminal congestive heart failure, unrelated to the neoplasm unless the "Goldblatt kidney" may have contributed to the cardiac hypertrophy.

EIGHTEENTH MEETING OF THE ASSOCIATION OF CONNECTICUT TUMOR CLINICS

DANIEL C. PATTERSON, M.D., *Chairman*
Bridgeport Hospital, October 17, 1940

THE PROGRAM this afternoon has to do with various aspects of cancer of the breast. I should like to make a few remarks concerning the causes of delay between the time when the patient first is afflicted with cancer of the breast and the time when proper treatment is instituted for this lesion. The reason for delay lies with two individuals, first, the patient and, second, the family physician or surgeon. The only way to overcome this delay is by the proper education of doctors and patients. These tumor conferences have already done a great deal toward educating the staff physicians and surgeons in what they should know about cancer and its treatment, but unfortunately only a few of the general practitioners not directly attached to the staffs of these hospitals have availed themselves of the opportunity to visit these tumor clinics. As the years go along we may be able to influence the general practitioner to attend these meetings and join in the activities. After the physicians are taught what they should know regarding cancer then the patients must be taught what they must do if they are to be protected from developing this disease or if they are to reach the doctor when the disease is still in the early and curable stage. The only way that these two objectives can be reached is by adopting the policy of periodic health examinations as advocated by the State Medical Society. The State Tumor Committee is now making a concerted drive to enlist the physicians of the state to adopt this plan as a routine procedure in their offices. Suitable follow-up cards are supplied, gratis, by the Cancer Division of the State Department of Health. A simple card index file will keep track of all your patients. I believe that the plan of subjecting your patients to a thorough complete physical examination once a year is an excellent procedure and it is only by this means that we shall see cancer cases in the precancerous stage and in the early stage when they can be cured.

PATHOLOGY OF BENIGN TUMORS OF THE BREAST

WILLIAM CLARK, M.D.

Benign tumors of the breast consist almost entirely of the so called fibro-epithelial tumors, fibro-adenomas and duct papillomas. However, a condition loosely called chronic mastitis which is not always classified as a distinct tumor formation will also be discussed in this paper.

Many of these benign tumors have a distinct tendency to change into cancerous lesions. A grave responsibility is therefore placed upon the shoulders of the pathologist because the surgeons will be influenced by the pathological reports rendered either to make a simple removal of the tumor or to perform more radical surgery. The future health and happiness of the patient and even her life will hinge on the correct diagnosis.

True benign tumors of the breast comprise 15% of all tumors in that location. A few of the rare ones might be mentioned, dermoids, chondromas, lipomas, etc., but these are so rare that they are of little practical importance. The more common benign tumors are of the fibro-epithelial group, consisting of the fibro-adenomas and the duct papillomas. The fibro-adenomas are divided into the intra- and pericanalicular types according to their place of origin but this distinction is purely pathological. They occur most frequently in young women under thirty years of age. They are painless and are slow growing. Simple removal of distinctly benign tumors is sufficient for cure but if these tumors contain secondary epithelial growths they are apt to undergo malignant degeneration and, in fact, they do so more often than other primarily benign tumors of the breast. They are usually solitary tumors and are quite firm and have a slippery feeling beneath the skin. They have a well defined capsule and are easily removed. On cut section they are firm but not stony hard and the cut surface shows trabeculations. The intracanalicular type often attains a large size, and the smaller ones are very often soft and

have a myxomatous appearance. The pericanalicular type rarely attains a great size and is hard and firm. Microscopic pictures show a well defined fibrous tissue growth around the ducts in the pericanalicular type and growing into the ducts and acini in the intracanalicular type.

The papillomas are very important from a clinical standpoint because they are considered precancerous. These are most commonly found near the areola ejecting from the walls of the milk ducts. They have a strawberrylike appearance, and the microscopic picture is that of a true papilloma consisting of a thin fibrous stalk covered with one or more layers of hyperplastic epithelium, branching and rebranching in a fern like manner. All structures are well formed except blood vessels which are thin walled. This probably accounts for the bloody discharge from the nipple that is generally an accompanying symptom.

The term chronic mastitis should be used to designate those affections of the breast that are characterized by chronic infection and resultant inflammation, but the term is usually applied to a variety of conditions of the breast associated with persistent pain and tenderness and a shotty or cord-like feel in various portions of the breast. The female breast is a semi solid glandular organ with specialized epithelial cells, that were originally derived from the sebaceous and sweat glands. A breast has from twelve to twenty lobes, each divided by an interlobar septum and each lobe consists of numerous small lobules composed of acini and milk ducts.

During the whole menstrual life of a woman the female breasts are undergoing constant physiological changes. These changes are under the control of the pituitary and ovarian hormones. Each month the breasts undergo distinct hyperplastic changes and the ducts and acini enlarge and branch out to a marked extent. The epithelial linings of the cells change to a high columnar type and there is a preponderance of glandular element over a supporting element. Glands and cysts enlarge in size and the epithelium may be piled up in several layers, in some cases projecting into the lumen in the form of fernlike papillary processes. This hyperplastic stage reaches its peak at the time of menstrual flow and in the postmenstrual period an involution occurs. Many of the ducts and acini disappear and atrophy, and the breast returns to its normal size. This cycle is known as the hyperplasia involutionary cycle. During pregnancy and lactation the

breasts undergo a more extensive hyperplastic stage and a correspondingly long involutionary stage. The perfect physiological cycle would consist of an equal amount of hyperplastic changes followed by an equal amount of involutionary changes and a return to normal of the gland structures but unfortunately this does not always occur. The breast seldom returns to the true involutionary state. There is, in other words, an abnormal if not truly pathological hyperplasia—involutionary cycle.

In many cases the hyperplasia resembles tumor formations and may be mistaken for them. Cyst formations are usually the rule, when the distended ducts and acini remain dilated and the lumen fills with epithelium which breaks down forming milky fluid. The pathological picture is that of hyperplasia and the clinical picture is that of cystic mastitis, as can be readily imagined. Different events of the cycle take place in the various lobes and lobules so that the pathological picture in different sections of the breast may not be the same. This accounts for the varied and numerous names given to this condition. The hyperplasia-involution is called abnormal mainly because it occurs at abnormal times, namely, after lactation or after the menopause. Although the breast changes have as many variations as a Bach fugue yet there is a central theme running throughout. This theme is the basic hyperplasia-involutionary cycle. The different names are simply different terms applied to the various stages of the basic process. Chronic mastitis is often confused with tumor formations but it is not neoplastic nor is it inflammatory as the name implies. The small round cell inflammatory zones seen around many of the cysts are considered to be due to the irritant secretion. Clinically both breasts are usually involved and palpation reveals small hard irregular masses which are tender to touch. The cut surfaces of these breasts are tough and rubbery and numerous cysts of all sizes are present, some containing straw colored and some cloudy fluid. The area is indurated and has not the stony hardness of carcinoma. Numerous pink and gray ducts can be seen scattered throughout. These are due to the hyperplasia. Microscopic pictures show all changes consisting of normal involution of primary epithelial hyperplasia and secondary epithelial hyperplasia in which the epithelium is extremely active and in some cases fills the entire acini and ducts. This latter condition is considered by some to be the nearest approach to true carcinoma, the only difference being that the growth is controlled

and limited by the membranes. It has not been shown that the breast which is the seat of cystic mastitis is any more susceptible to carcinoma than the so-called virginal breast. From a strictly pathological standpoint it would appear as though the changes would readily be precancerous, but clinical experience has not borne this out. The consensus of opinion seems to be that conservative treatment should be indicated. However, what would be considered conservative at the age of thirty would not necessarily be the same at the age of fifty.

CANCER OF THE BREAST

A statistical study

WILLIAM A. GEER, M.D.

The series of cases to be considered consists of patients with cancer of the breast who were admitted to the Bridgeport Hospital from 1928 to 1935, inclusive. The only cases excluded from the study are those which received their main treatment elsewhere and were admitted to the Bridgeport Hospital merely for irradiation or other forms of palliative treatment. From 1928 to 1935 there were 141 cases of cancer of the breast admitted to the Bridgeport Hospital for their main treatment. These cases are the ones under consideration here. In the series there were 140 females, only one male. The average age of the patients was 53, the youngest being 26, the oldest 82.

The most common first symptom was the patient's awareness of a tumor in the breast, this being the presenting symptom in 79% of the cases. In 15% pain and tumor were noted. Less common first symptoms were tenderness of the breast 2%, bleeding from the nipple 2%, pain in the breast 1%, and nipple retraction 1%. The average lapse of time from the first symptom to hospital admission was 10 months, the shortest interval being a few days, the longest 6 years.

On physical examination 43 cases, 30% of the total number, were noted to have palpable axillary nodes on the same side as the tumor. Physical examination of the axilla does not, however, give a reliable index of the presence or absence of axillary metastases; for in 99 cases where axillary tissue was examined by the pathologist, in 68 cases where no nodes were palpated before operation, axillary metastases were found in 39, and in 31 cases where nodes were palpated on examination, 6 showed no metastases. Thus, physical examination of the axilla

gives correct indication of the presence or absence of axillary metastases in only 55% of cases.

Of the total number of 141 cases, 11 were so far advanced when admitted to the hospital that only palliative measures were used. In the remaining 130 cases, operations were performed. Six of these patients died of some other cause than cancer of the breast before five years had passed, and were not included in the follow up study. In 8 cases follow up information could not be obtained. This leaves 116 cases of cancer of the breast treated by operation on which a follow up study has been done.

Simple mastectomy was done in 27 cases. There were no operative deaths. Seven of these, or 26%, were followed for five or more years without evidence of recurrence. The remaining 20 cases died of metastatic cancer of the breast. Local recurrence was seen in 27% of the cases on which simple mastectomy was done.

Radical mastectomy was done in 89 cases. There was one operative death, due to wound infection and septicemia. Twenty nine cases, or 33%, were followed for 5 or more years without evidence of recurrence. Local recurrence was seen in 25% of the cases on which radical mastectomy was done. The radical mastectomy cases were divided into those with and those without axillary metastases. In 56 cases where axillary metastases were found, 10 cases, or 18%, went five or more years without evidence of recurrence. While in 33 cases without axillary metastases, 19, or 58%, were followed for five years without evidence of recurrence.

The effect of postoperative irradiation was studied. Of the simple mastectomy cases, 16 were given postoperative irradiation. Of this group 25% went five years without recurrence, approximately the same results as those obtained in the simple mastectomy group as a whole. Of the radical mastectomy cases 15 of those without axillary metastases were given postoperative irradiation. Nine of these, or 60%, were followed for five years without recurrence; while in 18 cases without axillary metastases which were given postoperative irradiation, there were 10 five years cures, 56%. Of the radical mastectomy cases with axillary metastases, 19 were given postoperative irradiation. Four of these, or 21%, went five years without recurrence; while in 37 cases not irradiated and having axillary metastases, there were 6 five year cures, 16%.

SUMMARY

A follow up study has been done on 116 cases of cancer of the breast operated on at the Bridgeport Hospital between 1928 and 1935. The results are summarized in the following table:

Simple mastectomy: 27 cases
7 five year cures—26%
Radical mastectomy: 89 cases
29 five year cures—33%
With axillary metastases—56 cases
10 five year cures—18%
Without axillary metastases—33 cases
19 five years cures—58%
Effect of postoperative irradiation in radical mastectomy cases.
Irradiated cases without axillary metastases—15
Five year cures in 9 cases—60%
Non-irradiated cases without axillary metastases—18
Five year cures in 10 cases—56%
Irradiated cases with axillary metastases—19
Five year cures in 4 cases—21%
Non-irradiated cases with axillary metastases—37
Five year cures in 6 cases—16%

DISCUSSION

Doctor A. E. Lazlo, Bridgeport: I would like to ask Doctor Geer what is the difference in the percentage of cures in the cases that were radiated and in those that were not?

Doctor Geer: The difference was 5%, that is 16% of the non-radiated cases were cured and 21% of the radiated cases.

Doctor Paul D. Rosahn, New Britain: I do not think that this 5% difference is significant and should not be given too much importance because such a difference could be within the realm of statistical error.

Doctor Patterson: You are right; it is entirely too small a number of cases to warrant drawing any definite conclusion. There was a much larger series by Doctor Pack and his associates which was analyzed and this difference was not demonstrable.

RADICAL MASTECTOMY

JOHN SHEA, M.D.

So far the best results in carcinoma of the breast have followed the wide removal of the mammary gland together with the structures which are likely to be infiltrated by carcinoma cells. The breast and associated structures are dissected en bloc and it has been my experience that this can be done more completely, rapidly and satisfactorily through the use of a transverse incision, plus a longitudinal

incision along the border of the pectoralis major muscle. In practically all cases primary closure can be accomplished without difficulty. However, the incision used is a personal matter; other surgeons may obtain just as satisfactory results from different types of incisions.

The technic of radical mastectomy has been thoroughly standardized and the results are no better today than they were twenty five years ago. Halstead and Willy Meyer and many other surgeons of their time did as complete a radical operation as any surgeon of today and their results of 35-40% five year arrest of the disease have not been improved upon. The only way that the results can be improved upon is to operate immediately upon the discovery of a lump in the breast before the axilla becomes involved. Because one is unable to palpate nodes in the axilla previous to operation does not mean that the nodes are not present; many patients are fat and it is hard to palpate the axilla with any degree of accuracy. If the time between the discovery of the lump in the breast and operation could be lowered from ten months to ten days the results would show a wonderful improvement.

It is a well established fact that a scirrhus carcinoma appearing in a potentially active breast grows more rapidly than one which appears after the menopause. In my private practice I have estimated that one-third of the cases occurred in patients under the age of fifty and that these cases were much more active than those occurring in patients over fifty years of age. Dividing the breast into five areas, I have found that the most common site of occurrence is the upper, outer quadrant; next, the area beneath the nipple; third, the upper, inner quadrant; fourth, the lower, outer quadrant; fifth and last, the lower, inner quadrant. It is said that the constant arm movements affecting the upper, outer quadrant might be a factor in the greater frequency of a tumor in this area. If the carcinoma is situated in the lower, outer quadrant, fixity to the chest wall occurs at an early date. Likewise, a carcinoma in the lower, inner quadrant is apt to spread to the liver and peritoneal cavity.

I have never advocated preoperative radiation because I feel that it does not in any appreciable manner arrest the disease. As for the use of x-ray after operation, I have not used it routinely but I have seen definite benefit derived from its use for local skin recurrences. However, none of my cases that had local skin recurrence or recurrence in the

axilla have been cured either by radiation or secondary operation.

CONCLUSIONS

1. Surgery offers the best chance of cure for carcinoma of the mammary gland.
2. If we are to increase the five, ten and fifteen year period of arrest of the disease, operation must be performed when the malignancy is confined to the breast and there is no glandular involvement.

DISCUSSION

Doctor Oughterson: In our clinic in New Haven Hospital we are seeing more cancer of the breast cases in Stage 2 than we did previously and fewer in Stage 3, but still we have not increased the number of patients seen in Stage 1 and this first stage is the important one if a cure is to be obtained. I feel that our educational program must be increased if we are to influence this group of patients to seek earlier diagnosis and treatment. We should emphasize the fact that the only way to diagnose cancer of the breast is by a biopsy.

Doctor Patterson: There are some well-known surgeons in the country who say that if axillary glands are encountered that a simple mastectomy is advised and radiation of the axillary contents is depended upon. I do not agree with this but they may be right. I think also that there are a good many men who agree with me.

Doctor William S. Stone, Norwalk: A recent article by Warren is a meritorious effort to show that cancer of the breast occurs more frequently among women in Massachusetts who previously had chronic mastitis or chronic cystic mastitis. His extensive follow up shows that cancer of the breast occurs four and a half times more often in women of all ages who have or have had previous chronic cystic mastitis. In those from the age thirty to forty nine it occurs eleven and seven tenths percent more frequently, but after the age of fifty the percentage drops to two and one half per cent. In the admission department of the Memorial Hospital in New York we failed to note clinically any relationship between such benign lesions and cancer of the breast. Doctor Ewing, however, observed the frequent coexistence of chronic mastitis and cancer of the breast in the specimens removed at operation. This question whether or not chronic cystic mastitis is a precancerous lesion is an important one but in the present state of our knowledge I think we must be conservative in our treatment of chronic cystic mastitis. The cases of bleeding nipples often present a perplexing problem. The tumor or dilated duct in the areolar area may or may not be palpated but transillumination is often an aid in locating the distended duct. The late Doctor Peck, reviewing a series of cases operated upon at Roosevelt Hospital in New York found that about 50% of the duct tumors that were bleeding were malignant at the time of operation. However, if the tumor is confined within the duct the prognosis is good and in many cases only a simple mastectomy is indicated.

Doctor Nolan: A short while ago there was an article on simple mastectomy. As Doctor Shea pointed out, cancer so frequently occurs in the upper outer quadrant of the breast.

This man examined over 2000 specimens of breasts removed by simple mastectomy and inserted a cannular through which he injected the specimen with a dye and thereby proved that well over 20% of breast remains in the axilla after this operation.

Doctor Oughterson: I have nothing much to add to all this. There are a great many angles of discussion. I believe that the figures in our own clinic are comparative and they indicate that we are getting cancer of the breast earlier than we did years ago. However, in classifying the cases it seems that we have merely taken a group of patients out of stage 3 and put them into stage 2. We have not increased the number of patients first seen in stage 1, and this first stage is the important one in which we must first see these patients if we are to cure them.

I wish to second Doctor Stone's statement that the only way to diagnose cancer of the breast is by a biopsy. There are two reasons why this is not done earlier enough, (1) the failure of patients to realize the importance of a lump in the breast, and (2) the advice of doctors. Patients hear too often from their physicians that a little lump in the breast is harmless and not worry about it. A lump in the breast can never be harmless, and the diagnosis of such a lump can never be made clinically or by any other method than the microscope.

Doctor Stone: Do you adhere to that statement for all ages? I have many young patients around twenty who have lumps in their breasts, and some of these lumps go away. Should all these lumps be excised or biopsied also?

Doctor Oughterson: I would like to make this clear. I do not believe that I can tell from the character of a lump whether or not I am dealing with cancer. I know that I can rate a good percentage on such a basis on the correct diagnosis but it would be no help to the individual patient. Considering the incidence of cancer in this age group and considering the fact that Doctor Stone's reputation is well established, I would be very loathe to advise the removal of every lump in the breast but I would never say that it was harmless and I would watch it carefully. If it did not disappear within a reasonable length of time I would use more radical measures.

Doctor A. S. Laszlo: It is my opinion that the general practitioner sees many of these cases and that it is extremely difficult to draw the line as to how to advise the patient. It is a serious thing to tell a patient that the breast must be removed and are we really justified in doing this?

Doctor Patterson: We all agree with Doctor Oughterson that these lumps and masses should not be dismissed as harmless but should be watched.

Doctor W. A. Goodrich, Waterbury: How are you going to distinguish between the masses that are cancerous and those that are benign simply by watching them? I cannot see that any harm would result in performing a frozen section after excising the tumor; and if it proves malignant perform a radical operation, and if it proves benign nothing more need be done. A great deal of harm would result in watching a cancerous tumor. I think that they should all be excised, a frozen section done, and any following procedure governed by the report of the pathologist.

SIMPLE MASTECTOMY

JOHN O'CONNELL, M.D.

The simple removal of the breast without axillary dissection is performed in the following circumstances:

1. Large benign lesions of the breast.
2. So called inoperable carcinomas of the breast with metastases beyond the axilla, in the mediastinum, chest, or other zones, where the operation is simple mastectomy followed by some form of radiation therapy as a palliative measure.
3. In the bulky tumors, where the tumor has broken down into a foul sloughing mass. It is removed as a means of surgical cleanliness.
4. In elderly patients with a slow growing scirrhus type of cancer who are judged poor operative risks for radical operations and because of the slow rate of growth of the tumor, after simple mastectomy can be assured of a few years of comfort before recurrences develop.
5. In very early carcinomas of the breast with no demonstrable nodes in the axilla and where the operator believes that simple removal of the breast supplemented by radiation therapy yields results at least equal to the extensive dissection of the axilla with its resulting trauma. This is of course a point for argument, especially when metastatic glands of the axilla are discovered at a radical operation that were not discovered by careful palpation even in very thin individuals. In the Mayo report of 1935, 32% of patients with enlarged nodes had no carcinoma in the axilla while 29% without enlarged nodes showed definite axillary metastases.

The reports of favorable results for simple mastectomy in cancer of the breast are very often obtained from a selected group of cases which are used for statistical purposes, showing a high degree of cures. These are usually in localized types of cancer and in some forms of ductal cancer. Most statistics show better results in the radical operation group than in the simple mastectomy group, but we must keep in mind that most of the cases recorded under simple mastectomy are of the so called incurable type and these would naturally have a graver prognosis.

The use of electro surgery for simple mastectomy has a direct advantage over the scalpel method. This method allows for the division of tissues with closure of capillaries as well as arteries and lymph channels and sterilization of the operative field.

There is hemostasis of most of the larger vessels requiring less catgut ties to be left in the wound. The use of this method results in less operative manipulation and lessens the risk of extension due to this cause. There is also less chance of metastases along the line of surgical incision than with the scalpel method.

Patients, once thought hopeless, may receive many years of comfort following the simple removal of a breast. Sometimes the process becomes averted and no doubt a few actual cures result.

RADIATION THERAPY OF CARCINOMA OF THE BREAST

B. M. PARMELEE, M.D.

In order to evaluate the present role of irradiation therapy of carcinoma of the breast, it is necessary to remember the history of its development. Soon after 1900 the first malignant breast lesions were treated by x-ray. For fifteen years experimentation and empirical application was carried on with some success but with many disasters and failures. Following the development of the Coolidge tube, about 1915, more exact control was possible and voltages were raised from 100 to 200 K. V. with appropriate increase in the thickness of filters. Massive doses were given to single skin areas in one sitting. These changes improved clinical results. Since 1930 the divided dose technique has been employed. This allows the skin to tolerate several times as much exposure as the massive dose technique and thus increase the tumor dose.

We now have an international unit to measure dosage, called the R Unit and treatments can be fairly exactly duplicated. Shock proof equipment allows positions under the tube previously impossible. Experiments are now being conducted with 400 to 1,000 KV machines. From this it is clear that radiation technique is not static and in the analysis of five year groups it is usual that procedures have changed during the interval. Nevertheless, most clinics agree that radiation improves results.

Preoperative irradiation has not been employed in our clinic. It need not be used in stage 1 cases. In more advanced cases it should, theoretically, be useful but present methods cause too many surgical complications.

Postoperative therapy should be considered in every case. A stage 1 case without extension to axilla, demonstrated by tissue study, need not be

treated unless one judges the tumor to be one of rapid growth and high degree of malignancy. On the other hand, stage 2 cases with axillary involvement are benefited by radiation unless the tumor is one of a low grade of malignancy.

Recurrent disease in regional lymphatics and skin may be palliated and sometimes brought under control by suitable irradiation. Metastatic disease in bone and sometimes in lung or pleura may be favorably influenced. The degree of palliation varies widely in extent of regression and relief of pain and this again is relative to the grade of malignancy.

Recently, occasional spectacular results have been obtained by x-ray sterilization, producing an artificial menopause in younger women with extensive metastatic disease. Because of this, it is now considered good procedure to sterilize all women with breast malignancy who have not passed the menopause. By stopping the periodic stimulation and activity of breast tissue arising from ovarian secretions, it is theoretically probable that malignant breast tissue may be favorably influenced.

Radio sensitivity of tumors is a term frequently used. This must not be confused with radio curability. If a malignancy is high grade and growing rapidly, it may be said on pathological study to be radio sensitive, but the influence of radiation cannot be established in time to prevent local growth or wide spread metastasis. An example of this is inflammatory carcinoma. On the other hand, a tumor which has grown in five years to only a moderate size will usually be radio resistant and not be retarded by doses of radiation sufficient to produce necrosis in adjacent normal tissue. Such a case would be entirely a surgical problem.

This discussion indicates that routine radiation of breast malignancy can be improved by careful study of each individual case and consultation between surgeon, pathologist and radiologist. In this way, each patient will be treated by the safest combination of procedures known to us today.

Five year studies in this clinic support similar studies elsewhere that surgery plus irradiation gives better results than surgery alone. The percentage of differences is not great but it has increased slowly with the improvement in apparatus and technique. There are many experiments still in progress which promise well and will no doubt increase the value of radiation when used as a supplement to surgery in treatment of a majority of cases of malignancy of the breast.

DISCUSSION

Doctor Oughterson: It seems that we do not as yet know where we stand on postoperative radiation of the breast. It is also clear that these statistics even over a ten year period, as pointed out by Doctors Rosahn and Nolan, are not of sufficient size to be statistically significant. That is where I think our Association of Tumor Clinics could function in getting together figures on all these cases in the state.

Doctor Douglas Roberts, Hartford: In the early days when radiation was recommended postoperatively, it was because the surgery was not always adequate for the local field. I think today that the same conditions do not exist to the same extent. Surgery now tends to be more radical and more complete and thorough and the question of sterilization of the postoperative field by radiation is not as important as it was when the surgery was less efficient. However, this still may not be so with certain surgeons and in certain localities.

Something should be said for preoperative radiation. Its success depends largely upon whether or not the surgeon is aspiration biopsy minded. In order to properly use pre-operation radiation one usually depends upon aspiration biopsy to make the diagnosis. This presents a problem. Usually if no positive findings are obtained from two aspiration biopsies, the procedure is abandoned and operation instituted. Preoperative irradiation may be administered after incisional biopsy but usually if the frozen section shows malignancy complete surgery generally follows at once. Somewhat recently Coutard has advocated a short course of preoperative x-ray therapy, lasting eight to ten days, followed by immediate operation. This allows the period of radiation reaction to coincide with the healing period following the surgery. This shortens the period of treatment considerably without materially handicapping the operation and still retains the advantages of each procedure.

Personally I would advocate this form of preoperative radiation whenever practical. In Hartford we have become less enthusiastic about postoperative radiation. We have a voluntary agreement worked out with the ward surgical cases. In all Grade 1 tumors of the breast, whether they present axillary metastases or not, no radiation is recommended. For Grade 2 tumors no radiation if the disease is confined to the breast. In all higher grade tumors radiation therapy is given postoperatively to all cases.

Dr. Oughterson: I do not remember back so far but I have no doubt that Doctors Halstead and Warren did just as good surgery as we do today. From some figures collected at the Massachusetts General Hospital that dated back to the 1890's it was demonstrated that there was no significant difference in the surgical technique employed, but there was a slow steady improvement in the results of treatment. One explanation for this is that there is a great difference in degrees of stage 2 of the disease; that is, whether there is only one lymph node present or two or a great many.

TREATMENT OF RECURRENCES AND METASTASES IN CANCER OF THE BREAST

W. LEE WEADON, M.D.

Before discussing the various therapeutic pro-

cedures employed in the treatment of local recurrences and distant metastases in cancer of the breast, we must realize that these secondary manifestations are rarely cured and that the most that can be hoped for is palliation and alleviation of pain and other distressing symptoms. We might list the various lines of treatment under the heads of: 1. Prophylaxis; 2. Surgery; 3. Irradiation; 4. Drugs; 5. Local agents such as cold and heat.

1. Prophylaxis. Naturally the best way to treat any disease is to prevent it, and this can be done in the average case of cancer of the breast as far as local recurrence is concerned, in a very large percentage of cases (and in my experience this will average well over 80%), by a more radical excision of the skin and a more thorough dissection of the axilla, being careful in removing the axillary contents not to contaminate healthy tissue in the neighborhood. We have no regard whatever for the amount of skin that is removed and many times close the defect with a graft.

In addition to radical surgery as a prophylactic measure we give postoperative radiation in practically all our cases.

In dissecting the axilla and excising the breast we have had very little success with the Bovee unit but prefer a sharp scalpel, and believe we can do a more radical dissection with less damage to vital structures and less danger of contamination than with the Bovee unit.

When recurrences take place and involve rather small areas which can be excised, we prefer treating them surgically. When the whole chest becomes infiltrated, as it frequently does in extensive cases, then we depend entirely upon radiation.

When a growth occurs in the opposite breast it is difficult to determine even after operation whether it is a metastatic lesion or another cancer; and in the few cases that we have had, the pathologists have been unable to definitely say that the second growth was a metastasis. This is treated, when it occurs, by a second radical breast operation.

There have been a few cases of metastatic growths removed from vital structures such as liver and lung, but it seems too early to predict what the future will hold for these procedures. As far as surgical treatment for distant metastases is concerned, as in bones, chest, et cetera, we have nothing whatever to suggest and rely entirely upon irradiation, and when this fails we resort to the use of drugs and other physical agents.

Bone metastases particularly can be benefited by deep x-ray treatment and we believe the comfort of the patient is markedly increased and her life probably prolonged. The other more common location of metastases is somewhere in the chest, frequently the mediastinum. These are benefited very slightly by any treatment and in a good many instances we believe they have been aggravated by irradiation therapy.

The sterilization of the individual who is under the menopausal age we think is a very necessary procedure either as a primary treatment or most certainly when metastases develop. For the past few years all of my breast cancer cases who have not passed the menopause are sterilized completely and by surgery. This sounds rather radical but we have been impressed with some experimental work which has been reported relative to the finding of ovarian hormones in the blood of animals who have been completely sterilized by radiation and the lack of these same substances when the sterilization was produced by surgical excision of the ovaries. For this reason alone we have preferred the surgical method of sterilization.

I have been rather impressed with some of the reports of Doctor Percy of Los Angeles who uses a heavy cautery carrying a very high degree of heat in treating massive recurrences and his reports seem to be considerably better than one would ordinarily expect, but we have had no personal experience in the use of this method.

As far as the use of drugs is concerned, we rely entirely upon sedatives of various types and do our best to transfer the patient to the family physician when the end stage is approaching.

In the past few years we have tried all the new methods which have been suggested including pituitary extract, colloidal lead and gold, and the vaccine advocated by Doctor Connell of Queens, all of which have proven very disappointing. I might say that we have seen a few patients under medical supervision who have had colloidal gold and their terminal stage has seemed to be much more pleasant than in those cases who have had the ordinary type of treatment. If pains are located where nerves can be injected or located in the extremities and are intense, then procedures along these lines with alcohol injections of the cord are done.

Since Fay published his report of the local and general refrigeration treatment for inoperable car-

cinoma, we have become interested in this method of treatment and have used it in a limited number of cases. We have had two rather striking instances of extreme local recurrences and with generalized metastases, one of which is now dead and the other one probably will be dead shortly, but whose local lesions responded very satisfactorily under the application of cold for twelve hours out of the twenty four. In the general refrigeration treatment we have had one sudden death which occurred an hour or so after the treatment was discontinued and for which no cause was found. The suffering of the patients has been very markedly diminished and I can see no reason why this form of treatment should not be used in an effort to relieve pain in these hopeless cases.

DISCUSSION

Doctor Stone: To these of us who had the opportunity to observe the early efforts to apply the x-rays in the treatment of mammary cancer, the present estimate of their value presents a confusing and disappointing picture. Without the present more efficient machines and improved technique, we observed in the majority of cases a partial clinical regression of the primary growth. Exceptionally, there was an apparent complete regression. Frequently, also, cases judged to be clinically inoperable regressed to such an extent that a few weeks after treatment they appeared to be operable. Such observations led us to hope that preoperative x-ray treatment, routinely applied, would add to the salvage obtained by operation alone. Such a procedure met with quite universal opposition by the surgeon. To delay the operation would be dangerous. The operation was more difficult and hemorrhage was more profuse. Lastly, in the few trials of this procedure that were made, the patients often fell into the care of another surgeon before the cycle of treatment was completed. As a result we have insufficient data from which to judge the value of this procedure.

At the present time, it is quite generally accepted that it is well to apply the x-rays postoperatively. However, it is reported in high places that this procedure has not added to the salvage. It is therefore most generally believed, that the x-ray treatment should be reserved for advanced, inoperable cases, for local recurrences, and for some distant metastases. For local recurrences there is much evidence to show the value of this treatment, and there are numerous instances in which five year cures have resulted. In the cases of bone metastases pain may be often and markedly relieved. Except, therefore, for a few cases with local recurrences, and much to the disappointment of the present speaker, there is insufficient evidence to show that the x-ray treatment of mammary cancer has contributed much to the permanent cure of the disease. As a palliative procedure, however, there is much evidence to show its value.

Doctor Patterson: There was a recent report by McKenzie on the radiation of the ovaries in premenopausal breast cancer cases with encouraging results. He mentioned the fact that in the event of metastases, even in the bones, these lesions

responded favorably and some of them seemed to clear up entirely. I think that this is a very valuable adjunct to our treatment. He also pointed out that in 200 women treated over a period of twenty years for non malignant conditions by radiation there was only one who developed a breast cancer. He did not draw any conclusions from this but merely reported it.

Doctor Charles L. Larkin, Waterbury: As chairman of the State Tumor Committee I wish to take this opportunity to thank the authorities of the Bridgeport Hospital for allowing this Association to use the facilities of the hospital and for treating us so royally. I also wish to congratulate the men who have partaken in this program today. The papers have all been very interesting and very stimulating. The scientific data in these papers is based on the facts obtained from the standard clinical records and from the painstaking follow up records that are being used routinely here in this hospital. These papers show that we are making some progress here in Connecticut towards scientifically attacking the cancer problem because five years ago this hospital could not possibly have put on a meeting of this sort, due to the fact that adequate cancer records were not available.

This Association has been instrumental in having nearly every hospital in the state adopt the uniform cancer records and adequate follow up records. Photostatic copies of all cancer records in the State will be made by the Cancer Division of the State Department of Health. These records will be thoroughly studied and analyzed and it is our hope that the studies will solve many of these problems that have been discussed here today.

The problem of the value of preoperative and postoperative radiation of these cases of carcinoma of the breast may well be solved by such study. In treating cancer of the breast, I, personally, use all three forms of cancer therapy, i.e., x-ray, surgery and radium. I think that each one of these methods has a place in the treatment of cancer and a happy combination of all three methods will give better results than the use of only one or two of these methods. I advocate using a sterilizing dose of deep x-ray therapy as described by Doctor Roberts, i.e., 1000 R directed through two portals through the breast obliquely and 1000 R in the axilla. This is given over a period of two weeks, and is given not in the hope of killing the cancer cells present but to fix the anaplastic cells that are about to be disseminated into the lymphatic channels or capillaries. The thought behind it is that there will be less chance of spill and dissemination of the cancer at the time of operation, which is done at the end of two weeks.

The operation consists of a radical mastectomy, including the pectoralis major and minor and dissecting out the glands of the axilla very thoroughly. 100 mgms. of radium in two tubes in tandem screened with a 1 mm. of brass and 1 mm. of rubber is inserted beneath the skin along the axillary artery and vein and left in place for 24 hours. The radium is easily inserted after the upper half of the wound is closed by making a skin incision in the middle of the clavicle and another incision of the skin in the axilla. The radium is placed inside a Penrose drain without the gauze and the Penrose drain placed so that one end comes out the incision over the clavicle and the other out the incision in the axilla. I have treated only a limited number of such cases by this means

but I have not seen any untoward results by using this method. There is no more swelling of the arm in these cases than you will find in the cases that do not have preoperative x-ray and radium. When the axillary nodes and lymphatics contain metastatic growths it is practically impossible in the majority of cases to thoroughly remove all cancerous cells. The palpable nodes and the fat can be removed but undoubtedly many microscopical cells remain that cannot be seen by the naked eye or felt by the palpating hand and it is these cells that we hope to kill by the use of radium.

I am very interested in the report that mortality statistics are no better today than they were in the days of Halsted. I think this is probably true and is due to the fact that the same problem remains today that was present in the days of Halsted, that is that we are not getting cases at an earlier stage today than we were twenty-five years or thirty years ago. If we do not succeed in getting these cancer cases at an earlier stage, i.e., Stage 1 where the disease is still located in the breast itself and has not extended to the axilla, there is little hope of improving our mortality statistics. The only practical way that this can be accomplished is by the universal adoption by every practitioner of the plan advocated by your Tumor Committee, a yearly examination of every patient over 35 years of age by a competent medical practitioner. I also advocate what Doctor Oughterson says about education of the public and profession. There is a crying need for more publicity amongst the lay people and this will be remedied, in the near future I believe, because the State Tumor Committee has already affiliated itself with the American Society for the Control of Cancer and a branch of the Women's Field Army is to be established. It is hoped that adequate publicity will be obtained by disseminating cancer propaganda through this organization.

A small minority of the medical profession have increased their knowledge of cancer by attending meetings of the tumor clinics throughout the state but unfortunately a large majority of the profession have not availed themselves of the opportunity. One of the great problems of the future is how to teach these doctors what they should know about the prevention and cure of cancer.

Do You Feel This Way?

I don't believe many physicians working on a salary would take the punishment I have absorbed struggling to make a living under the fee system. I honestly don't believe I could put the same intensive effort into the care of the sick for a definite wage. There would not be the relentless driving force—the prodding stimulus—the ambition urge. There is

an unpleasant uncertainty about a doctor's income that forcibly eliminates the tendency to develop a lazy leg. Competition with other aspiring men keeps one stepping briskly forward lest an impatient hard-won clientele drifts away.

These are impelling forces that send a doctor forth—when half ill, often wholly so, or when dog-tired, aching unmercifully for rest and sleep—to act his part like a good troupier so that the show may go on. I have gone on calls when it was agony to start such an expedition; returned home weary, with nervous battery exhausted, limp as a drowsy angleworm; then dragged out again.

I have done this for a fee—sometimes received, sometimes not—I wouldn't do it for a salary if I could help myself. I fear it couldn't put the requisite "umph" into it.

I am positive I can keep up more steam on less money from fees than I could if I received a bigger amount from a salaried sinecure, and I know I can give my patients more value in service for their money. Perhaps if I were employed by a Mayo clinic, did just one specialized job with assistance galore to do the tedious work, my viewpoint might change. I am convinced that most medics who are worth their salt feel the same way.

From "*Group Medicine Answered*"
Floyd Burrows, M.D., N. & State J. M.

Tuberculosis mortality acts something like a social barometer, rising during wars, and rising highest in the countries most affected by the war. It is difficult to prophesy what the present war will mean in increased tuberculosis mortality in the belligerent countries, but we may be sure that it will be once more a true barometer of disturbed social conditions. Countries which are making the greatest efforts, which are keeping their industries keyed up to the highest pitch, working their men the longest hours and reducing standards of living to the lowest levels are bound to suffer severely.

Frank C. Boudreau, M.D., *New Digest of the Milbank Memorial Fund*, June 1940.

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STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

A FAMILY HISTORY INFLUENCES TREATMENT AND PREVENTION

MAUDIE MARIE BURNS, M.D., *Hartford*

The Author. B.A. and M.D., *University of Texas.*
Clinical Psychiatrist, Bureau of Mental Hygiene,
Conn. State Dept. of Health

MUCH HAS been written in recent years emphasizing the importance of the social history in the diagnosis and treatment of general medical conditions as well as psychiatric problems. It has been frequently pointed out that one of the major assets of the general practitioner was his knowledge, extending over years, of the family history of his patients. The importance of this kind of knowledge about the patient was recently emphasized in three children referred by a general practitioner because of neurotic symptomatology. This physician had successfully treated three generations of this family, and it was his intimate knowledge of the social patterns which existed that not only affected his treatment of organic conditions of the family but gave understanding to the source of the neurotic symptomatology of the children; which appeared due not to certain neuropathic traits present but to a definite family pattern of living.

This pattern of living appears to have had its origin with the maternal grandparents of the children seen. Of these maternal grandparents there were seven children, four daughters and three sons. All three sons married and had children, one daughter died at an early age of tuberculosis, one daughter remained unmarried and was later hospitalized as psychotic; the two remaining daughters married and had children. It is in the family history of the paternal grandfather of the patients that the neuropathic trait mentioned appears, there being an aunt, a brother, a daughter, and a granddaughter of the paternal grandfather who apparently were psychotic but the psychoses of these individuals do not seem to follow very definitely characteristic hereditary patterns. There is one grandson of these grandparents who may be retarded mentally according to hearsay evidence about him. As far as can be ascer-

tained by careful study, these constitutional traits, hereditary or not, had less influence upon the children than the emotional tone and reaction to situations which was laid down as a sort of family characteristic by the maternal grandmother. This grandmother dominated her family completely and about her all the strong family and home feeling revolved for even a generation past her death. She was a woman who followed a pattern of dominance through illness. She suffered from many imaginary complaints, and, even in her later years with definite organic disease, instead of compensating for the disability, she used it in a neurotic way. It served as a tool to bind her family closer to her, and served to strengthen her hold upon the family, all of whom were completely and wholeheartedly devoted to her.

The unmarried daughter gave up all her social life and contacts outside the home to remain at her mother's bedside for eight years prior to her mother's death, leaving her only for short periods when she might glean some tidbit of gossip with which to entertain her mother. It was this same daughter, who, in speaking of the "beautiful thoughts" of one of the patients, an 11 year old girl, said that she had such a wonderful concept of death, she looked forward to it and eagerly anticipated it as a time when she might rejoin her wonderful grandmother. One of the married daughters with two small children living in another community would return home by the day to be with her mother whenever possible, and finally, after living in the other community and owning a home there for twenty years, moved her family back "home." She was the only one of the group who had made any effort to break away and she was unsuccessful. The other married daughter moved her family back to the old homestead, following the death of her parents, to be with the unmarried daughter and to keep the home together. The un-

married daughter then assumed the position which the mother had had in the family. All three of these daughters were quite closely tied to their mother and remarkably dependent upon her. All three followed very closely her pattern of "retreat into illness." All had difficulty with their menses and complained of "flooding" spells and this symptom is apparent in most of the granddaughters also. One of the daughters complained of a period of nervousness during menopause, another gave a history of anxiety attacks and much illness as a young girl, and the third followed a pattern of illness that very closely paralleled that of her mother. She was always taking medicine, treatments, and being examined for various and sundry imaginary ailments. Both the married daughters have as husbands rather passive men, who followed the pattern of the father and allowed their wives to dominate their home as their mother had done before them.

Of the sons of this maternal grandmother, less is known as to their handling of their own illnesses but they are described as individuals who were never entirely adequate in their adjustments with other individuals. They tended to be somewhat effeminate in their manner, immature in their speech and compensated in various ways for their personality defects and difficulties in social adjustment. They were all quite devoted to their mother and in their marriages, all married women who, for one reason or another, were allowed to dominate their homes much in the manner of their mother. In two instances, it appeared that while these wives were healthy at the time of marriage, they soon became ill and used this illness to dominate the home. One of the grandsons, against the advice of his physicians, married a girl who had a severe organic illness with poor prognosis, thus tending to follow in his father's and grandfather's footsteps in choosing a wife who would hold the center of the stage through illness.

Of the three grandchildren of these grandparents seen for study, one, a girl, followed the pattern of illness with little or no organic pathology discernible, and when there was organic disease evident, she used this in a neurotic fashion to gain attention and to dominate. Once, when hospitalized, she saw someone vomit, she immediately vomited as she "thought that was the thing to do." During the course of a long illness for which there was little organic evidence, she remarked that it was fun at first with everyone coming to see her and bringing

her presents but when this ceased she became bored with it. This girl developed many fears and anxieties of a severe nature during the course of her illness.

Another patient, a brother of the girl, was a somewhat infantile, somewhat effeminate youngster who was quite tied to his mother and having difficulties in his social adjustments with children his own age. He presented mild symptoms of anxiety.

The third patient, a boy, and a cousin of the first two, was an overgrown, adolescent boy, rather effeminate in his makeup, who was quite tied to his mother and unable to make a decision without her. He showed great concern over the most minor illnesses and although often ill with symptoms of an organic nature, showed in handling these many symptoms of a neurosis along with various fears and anxieties.

It appeared that the individuals in both generations following the grandmother were strongly influenced by her in their failure to develop into mature, emotionally adequate persons. The daughters closely followed the maternal pattern in relation to illnesses and in their dominance in their homes; while the sons, equally or more devoted to their mother than their sisters, tended toward an effeminacy and somewhat of an inadequacy in their social development and followed the home characteristic of allowing their wives to be the dominant force in the home. Among the grandchildren, the girl seen followed the feminine pattern with more pronounced anxiety symptoms than had been evident in either of the two preceding generations. The two boys, on the other hand, appeared to combine many of the effeminate, passive, immature traits of the males and the anxieties and preoccupation with illness of the females from the preceding generation.

These three children seen were the children of the daughters of the grandparents. Among the children of the sons of the grandparents, there is hearsay evidence of milder symptoms of like nature and it is possible that more detailed study would bring out evidence of neuroses of varying degrees of severity fitting into this same family picture.

Among this family as a group, two grandparents with seven children and a number of grandchildren, there is much illness that is definitely organic in nature. These organic illnesses may have influenced the development of the emotional and personality characteristics shown through a lowering of the resistance of the individual and his ability to cope with a situation. But, in this study, it appeared that

no matter what kind of organic illness was present, these people all tended to utilize these illnesses in the same way. It would appear, further, that the predominant factor in the picture one sees as characteristic in this family was dependent not on any neuropathic or organic factor present in the family, but was dependent upon a social factor operating in a family situation set up by the maternal grandmother. This maternal grandmother married a man who could assume a passive role in the family and allow her to dominate, which she did through illness. Of their four daughters and three sons, one daughter died at an early age, one remained unmarried and prior to the development of a psychosis, played a dominant role in the family; the two other daughters married passive husbands whom they could dominate and this they did largely through illness; all three sons followed their father's example and assumed a passive role in the family, allowing their wives to assume the dominant part in the household. Among the grandchildren, one boy has married and followed the example of the grandparents and parents in his marriage, choosing a wife who was definitely ill and around whose illness the household would revolve.

From this study then, the symptoms in the three children seen, however much they may have been influenced by any organic or constitutional factors from a hereditary point of view, and whether or not the children later develop psychoses, appear to have had their origin in a social manner of living set up by the maternal grandmother. In the routine social history taken on a single patient, a picture such as this could be very easily missed, and, quite possibly, the constitutional and neuropathic traits would appear to overbalance any social factors present. However, the intimate knowledge gained through many years of study of this family enabled the family physician to recognize this and utilize his knowledge to obtain help for these children as a preventive health measure to give them greater opportunity to develop into mature individuals.

The Clinical Interpretation of Blood Iodine Levels

D. S. RIGGS, E. F. GILDEA AND E. B. MANN

Departments of Internal Medicine, Physiology and Psychiatry of the Yale University School of Medicine and the Metabolism Service of the New Haven Hospital

Presented before the 16th Clinical Congress, Connecticut State Medical Society, Hartford, May 17-19, 1940

THE IMPORTANCE of blood iodine determinations in the study of thyroid functions has been clearly established. Yet different methods have given such widely varying values that the diagnostic significance of blood iodine estimations has been debatable. The small amount of iodine contrasted with the large amount of organic material in blood makes the determination difficult. During the past two and a half years we have developed and thoroughly tested a permanganate acid ashing distillation method, which eliminates most of the difficulties of the older methods. The blood is oxidized by heating with potassium permanganate and sulfuric acid. The iodine is then separated from the digest by reduction with oxalic acid and is finally determined in the distillate by a starch thiosulfate titration.

Duplicate analyses of iodine have been determined in the blood of twenty normal subjects, of more than twenty clear-cut hyperthyroid patients and of at least four patients with hypothyroidism. The blood iodines of the ten normal male and ten normal female subjects ranged from 2.5 to 3.7 with an average of 3.1 gamma per cent. In clear-cut hyperthyroidism the amount of iodine in blood was elevated. In most instances the level was from two to six times our highest normal quantity. The patients with spontaneous myxedema or with post-operative hypothyroidism had blood iodine values well below the normal range.

A New Journal from the Coöperatives

The sponsors of coöperative medicine are now publishing a quarterly journal called *Medical Care*, the first issue of which appeared January 27. The new journal is a non profit enterprise under the auspices of the Committee on Research in Medical Economics, Inc., 1790 Broadway, New York, with

Michael M. Davis, Chairman of the Committee as editor.

Its stated purposes are "to disseminate information concerning the economic and social aspects of medicine, to promote a scientific approach to the subject, and to stimulate practical action by the professions and the public in their common interest."

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MANUSCRIPTS: Manuscripts should be type-written, double-spaced, on white paper 8½ x 11 inches. The original copy, not the carbon copy, should be submitted. Carbon copies or single-spaced manuscripts will not be considered.

Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month—day of month if weekly—and year.

Used manuscripts will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

ILLUSTRATIONS: Illustrations, tables, etc., should bear the author's name on the back and the figure number. Photographs should be clear and distinct; drawings should be made in black ink (preferably India ink) on white paper. Used photographs and drawings are returned after the article is published, if requested.

NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physi-

cians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS: All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS: Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS: Reprints of papers and obituaries may be obtained from the Editor at cost.

EDITORIALS

Progress by Metamorphosis

Five years ago this August the JOURNAL made its appearance first as a quarterly and then, somewhat more than a year later, as a monthly. During all this period there have been no substantial changes in appearance or contents. To the Editorial Board the time now seems suitable for a change in the cover and in the type and format of the JOURNAL. With a border of colonial red it should appeal to the eye and with changes in arrangement reading should be facilitated.

As Chairman of the Council which conceived the idea of the JOURNAL, it is fitting that Doctor Miller's paper should be honored with the leading position in this number. He has presented many well conceived and logical ideas bearing on medical practice in the future. A series of historical articles is being collected by Doctor Thoms to be published monthly, beginning with April, and eventually to appear in book form at the time of the Sesquicentennial of the State Medical Society.

The section on Medical Preparedness and the Legislative Section will continue to appear each

month and the Hospital Section is developing as a result of the interest of the State Hospital Association in the JOURNAL.

It is the hope of the Editor that these changes and innovations will be even more pleasing to the many readers who in the past have expressed their appreciation of the JOURNAL.

Cancer and the Women's Field Army

For a long time the Tumor Committee of the Connecticut State Medical Society has realized that an insufficient amount of cancer education of lay persons has been effected in the State of Connecticut. To remedy this condition, the Tumor Committee has affiliated itself with the American Society for the Control of Cancer, Inc., and is now organizing a Women's Field Army. There are today some 200,000 women in 46 states actively engaged in this work, and Connecticut is the last state to organize such a group. The program of the Field Army is chiefly educational and was devised primarily for the purpose of influencing patients to seek proper medical care before their cancers have reached the

advanced states when they are no longer curable, and what is even more important, of advocating the annual physical examination by which means precancerous lesions which can be cured may be detected and treated before they undergo malignant change. Therefore, through the distribution of cancer propaganda, the Army hopes to reduce the incidence of cancer, and it also hopes to influence patients to avail themselves of the modern methods of treatment and prevention which are at their disposal.

The Field Army tends to direct its work as follows:

1. To teach the public and interest the medical profession in the value of complete periodic physical examinations of apparently well individuals as an important measure for the control of cancer as well as other chronic diseases.

2. To teach the public the early signs of cancer and the significance of these signs when present.

3. To emphasize the fact that many forms of cancer in the early stages, when treated adequately, are curable.

4. To drive home to all intelligent persons the fact that the control of cancer is a personal matter, in that they must take the first step toward this control by asking the physician of their choice for a periodic physical examination and advice regarding further steps to be taken, if necessary.

5. To remove unreasoning fear of the disease from the public mind by replacing fallacies and misinformation with known facts.

6. To warn the public against all persons advertising or guaranteeing cancer cures, something which no reputable, ethical physician will do.

C. L. L.

Non-Repetative

The simple act of writing a prescription many times in one day should become more than a routine gesture. The use of old gunshot prescriptions with their manifold ingredients is a thing of the past. The failure to foresee the aftermath of the writing of the prescription in relation to the individual patient is one of the commonest errors.

Pharmacists inform us that it is not an uncommon occurrence for the customer to request the repeated filling of a single prescription, the contents of which taken over a period of time cease to be beneficial and in some instances are actually harmful. The alert pharmacist will not only fill the pre-

scription but will carefully scrutinize the contents lest there be any incompatibility or error in dosage which may have been inadvertently overlooked. The reliable pharmacist will also weigh the advisability of repeatedly refilling a prescription unless specifically requested by a physician. This necessitates a close coöperation between the pharmacist and the physician. The physician must protect his patient from the possibility of such a circumstance by the use of the code letters "N.R." affixed to the prescription. The trend in prescription writing has been toward greater simplicity, but in spite of this there must be some method of safeguarding, not only the patient, but the physician and the pharmacist as well.

Academy of Pediatrics Meeting in New Haven

On March 27, 28 and 29, Region Number 1 of the American Academy of Pediatrics will hold its annual meeting in New Haven. The Hezekiah Beardsley Pediatric Club is actively participating in the program for the entertainment of the three or four hundred pediatricians who will be present. The program promises to be one of the most interesting ever presented at any regional meeting.

There will be twenty-five speakers of outstanding authority to discuss the various topics. Those responsible for the program very fortunately were able to persuade the Beaumont Club to incorporate its annual lecture in the program. The guest speaker, Richard H. Shryock, PH.D., Professor American History at the University of Pennsylvania, will discuss "Advent of Modern Medicine in America." The general public is invited to this lecture.

The complete program appears on page 236.

Headquarters for the meeting are at the Taft Hotel, New Haven, Conn. The Scientific Program will be held in the Auditorium, Sterling Law Building, Yale University.

Additions to List of Publications of Members

The following was unintentionally omitted from the List of Publications of Members, July 1, 1939-June 30, 1940.

Perkins, Charles W.: Roentgen-ray treatment of skin cancer. *Radiology*, 33:191-195, August 1939. Liposarcoma of the mediastinum and lung. *Am. j. roent. and rad. ther.*, XIII: 3, Sept. 1939.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
258 CHURCH STREET NEW HAVEN

The President Opens Membership Drive

One of the objectives of Doctor Landry's administration as President of the Society has been to increase the membership. As his year in office comes to a close he has added his help to the constant effort of the Secretary's Office to have every eligible Connecticut physician a member of this Society.

The Secretaries of each of the County Associations have been furnished with accurate lists of non-members and a large number of applicants is expected at the April meetings. It is realized that all physicians included in the enumeration are not eligible for membership but the comparative figures are given as a matter of general information.

	MEMBERS	NON-MEMBERS	TOTAL	% MEMBERS
Fairfield	395	212	607	65
Hartford	537	136	673	79
Litchfield	79	19	98	80
Middlesex	68	17	85	80
New Haven	523	248	771	67
New London	120	27	147	81
Tolland	20	8	28	71
Windham	40	8	48	83
State	1782	675	2457	

The Fairfield County Association has a special Membership Committee headed by Doctor James D. Gold.

Council Meeting

The Council held its monthly meeting on February 5.

Attending Staffs for State Institutions

For some time the Council has been considering the matter of physicians serving as members of attending and consulting staffs of tax supported state institutions and now recommends:

"That State institutions should staff themselves to provide medical care to meet the ordinary medical needs of the institution and such special needs as the requirements of the institution would justify. Extra-

ordinary demands beyond the abilities of the resident staff should be cared for by outside physicians recompensed upon an appropriate fee basis."

Principles and Recommendations of the Joint Conference Committee

The Principles and Recommendations of the Joint Conference Committee of the Society and the Connecticut Pharmaceutical Association were discussed at length and some changes suggested. Action upon their adoption was postponed until further consideration could be given.

Doctor Howard to be Delegate to Connecticut State Dental Association Meeting

Doctor Joseph H. Howard of Bridgeport, Chairman of the Society's Committee on Public Health was named delegate to the Annual Meeting of the Connecticut State Dental Association, Bridgeport, April 30th, May 1st and 2nd.

The Death of Doctor Loomis

Doctor Frank N. Loomis of Derby died on February 3rd; aged 82 he was one of the oldest members of the Society and had been a member for fifty-five years. Doctor Loomis was a busy and respected physician in the Naugatuck Valley for over half a century and during all of that time was active in the affairs of the New Haven County Medical Association. Until lately he never missed a meeting of the Association, and was its president in 1910.

Society Represented at Annual Congress on Medical Education and Licensure

Doctor Thomas P. Murdock, Secretary of the Connecticut Medical Examining Board and Doctor Samuel C. Harvey, Professor of Surgery, Yale Medical School, represented the Society at the Annual Congress on Medical Education and Licensure in Chicago in February. Doctor Harvey took part in the program with an address on "The Objec-

tive of Medical Education" and Doctor Murdock participated in the Round Table Discussion of the Federation of State Medical Boards.

Committee to Revise By-Laws

The Committee to revise the By-Laws of the Society under the chairmanship of Doctor D. Chester Brown, is continuing its careful study of the Charter and By-Laws of the Society. It will make a progress report to the House of Delegates at the Annual Meeting.

Committee on Public Policy and Legislation

The Committee on Public Policy and Legislation met on Sunday, February 9th.

There were present: Commissioner of Health, Stanley H. Osborn, James R. Miller, Arthur B. Landry, Berkley M. Parmelee, D. C. Y. Moore, Edmund L. Douglass, Ralph B. Thayer and the Chairman, Creighton Barker.

Absent: George Blumer, Harry B. Hanchett, Joseph A. Beauchemin, Cecil R. Garcin.

The Committee reviewed and discussed nearly 150 bills having to do with medicine, health and welfare that are pending before the 1941 General Assembly. Action was taken and legislative policy decided concerning about half of this number. Other measures were not considered sufficiently pertinent to the affairs of the Society to require Legislative appearance.

Lengthy discussion was had concerning S.B. 529, the Model Health Insurance Bill of the American Association for Social Security, which has been introduced into the Senate by Senator Alfred Bingham of the 20th District. This is the first time that a health insurance bill has been introduced in the Connecticut General Assembly and because of its complexity and importance the Legislative Committee directed the Chairman to appoint a special sub-committee of three members to study this bill and to report to Legislative Committee at a later date. The Chairman appointed to the sub-committee, Chairman, President of the Society, Arthur B. Landry, James R. Miller and Edmund L. Douglass.

"Is Your Hospital Quiet?"

"In this business world, when a product ceases to give customer satisfaction, or when an organization ceases to provide a service that meets with popular

demand, both start to slip. The public wants service, it wants what it feels it is entitled to receive for the money it pays.

"Now, we do not wish to infer that our hospitals charge too much, or that they indulge in any dangerous practices, for such is not the case. Our criticism of local hospitals has to do with those little things that make or break an institution in the eyes of the public.

"Our hospitals are noisy, far too noisy. Too frequently nurses bang through doors, and we do mean bang. These same angels of mercy are most careless in the handling of dishes and pans. The noise is nerve racking to the sick and disturbing to the ill; in fact noise, noise and still more noise is driving paying guests from some hospitals and earning a reputation for these local institutions that is far from desirable.

"The voice of complaint is rising higher among those people in our city who can afford to enjoy hospital service, and this is bad, for a little more care on the part of hospital management could correct the situation to the mutual benefit of all. And this is our tip to all of our hospitals: within your four walls live up to the sign on the lawn outside, which reads Quiet Hospital."

Newspaper editorial copied in Northwest Medicine, June, 1940.

High Lights from "War Medicine"

Much of the loss of time among civilian employees in navy yards due to preventable illness can be greatly reduced if the problem is attacked by an annual physical examination of all employees, men requiring curative treatment being referred to their private physicians or to other agencies.

Over fifty per cent of the crashes in aviation can be attributed to the pilot, and generally poor judgment on the part of the pilot will cover many mishaps.

March fracture, the name which implies that the condition is associated with marching, may be seen in persons who are engaged in activities not connected with military service.

The drug industry today is in a much better position to supply the medical profession, hospitals, the Red Cross, the War Department and governmental agencies with pharmaceuticals and medicinal chemicals than it was during the World War.

THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

William W. Backus Hospital, Norwich

In the annual report of the William W. Backus Hospital, Doctor Maurice R. Moore, Superintendent, reviews the work of the year as follows:

"There were 620 major operations, 1,539 minor operations and 577 accident and dispensary cases cared for by our surgical department. The Maternity department has been exceptionally active. Here we had an increase of 24.3% cases. One anticipates that hospital deliveries will continue to increase as the public more and more realizes the added safety which is available to both the mothers and babies by hospitalization. We admitted 433 more patients to the institution than in the preceding year. This accounts for 3,733 more hospital days than last year. In spite of the marked increase of patients there have been 19 less deaths than in the 1938-39 fiscal year. Surely one is justified in concluding that this decrease of loss of life when considered with our increased activity is not an accident but may well be credited to earlier diagnoses and better treatment facilities."

The statistical report showed:

	1939	1940
Number of patients admitted during the year	3,183	3,616
Number of out patients admitted during the year	1,652	1,544
Average number of days stay per patient	10.9	10.9
Newborns discharged	484	602
Deaths	203	184
Number of autopsies	75	56
Cost per patient day	\$5.85	\$5.63
Income per patient day	\$3.99	\$4.01

The Elks "Blood Bank" has been active throughout the year. It is difficult for one to express fully one's gratitude to the members of that organization for the service that they render the community and our hospital.

Considerable new and needed apparatus has been added to the hospital equipment. It seems fitting that one enumerates here these purchase, which are:

1 Metabolism machine	12 Gatch beds
1 Chart rack and 20 chart holders	5 New mattresses
	1 Infra red lamp

1 Truck for wards	1 Clock, Victor Interval
2 Electric clocks	2 Anaesthesia tables
2 Electric sterilizers	1 Heated tray conveyor
3 Instrument and dressing tables	10 Bedside tables
	1 Photoelectric colorimeter

When one considers that almost all of this apparatus has been purchased by money, received through the letter campaign, one understands the justification of requesting community aid. The campaign to raise funds was started June 1, 1940. The funds are specifically to be used now to purchase new equipment. While such purchases appear our greatest present requirement, one anticipates the time when one may use such funds for other needed purposes.

Bristol Hospital

The following figures for the year 1940 at the Bristol Hospital represent an increase of 26% over the year 1939.

Patients admitted to hospital	3,707
Number of in patients treated	3,788
Admitted to out patient department	1,606
Newborn	547
Cost per patient day	\$5.99

In the maternity department there were 547 babies born, an increase of 74 babies over 1939 which is an indication of the crowded condition of this department.

The Bristol Hospital has added to its staff a full-time Roentgenologist, Doctor Ralph J. Littwin, to take charge of the X-ray Department.

During the year some very nice gifts and money were received as the following will indicate: \$1,000 check, \$300 check, steam table for the kitchen, a Champagne operating room table, two oxygen tents, a stethograph, double x-ray view box, also the re-decorating and refurnishing of a private room and the repainting of various rooms throughout the hospital.

Grace Hospital, New Haven

A scientific meeting of the State Tumor Clinic will be held at Grace Hospital on March 6 at which time it is expected members of tumor clinics

throughout the state will be in attendance. A very excellent program has been prepared by the local physicians.

Doctor Pasquale A. Piccolo, who has been Resident in Medicine for two years, will spend his third year of residency at the Boston Dispensary, New England Medical Center.

Doctor Simon Doff has been appointed Medical Resident beginning July 1, 1941, after serving two years rotating internship here.

Doctor Samuel A. Jaffe has been appointed Resident in Surgery beginning July 1. He is now Assistant Resident in Surgery and, previous to that, completed a two year rotating internship here.

Doctors Albert Robbins and Jules Levin have been appointed Assistant Residents in Surgery after completing two year rotating internships on July 1.

Doctor Arthur G. Wilkinson, who will complete three years of residency in Gynecology and Obstetrics on July 1, will start practice in New Haven. Doctor Clayton S. Hitchins, Jr., from Johns Hopkins Hospital, has been appointed Resident in Gynecology and Obstetrics.

Greenwich Hospital

A report from the annual meeting of the Board of Directors

The past year has been a noteworthy one in the history of the Greenwich Hospital Association. It has witnessed the successful conclusion of the campaign to raise funds for the construction of a new hospital. \$1,000,000 is now available for that purpose. The Building Committee has been at work for more than two years and within a short time will have in its hands detailed drawings and specifications for the unit housing the heating plant, laundry and help quarters. Contractors' bids will be asked thereon and it is hoped that work may start shortly. Detail drawings covering the hospital unit are in process and will require about four months. It is hoped that construction may be started during the summer.

The Board of Directors was re-elected and the officers of the Board elected were: President, Hugh D. Marshall; Vice-President, Arthur H. Carter; Treasurer, H. Ernest Buermeyer; Secretary, E. Dimon Bird.

The past year saw an addition to present facilities of four private rooms and sixteen semi-private beds. This was accomplished by the enclosure of the existing six porches. Without this addition it would have

been impossible to care for the maximum census which was 126 patients.

Patients admitted during 1940 were 675 to private rooms, 686 to semi-private, 1,525 to wards.

Classified as follows:	Patients	No. of Days
Private (paying full rates)	1,351	14,486
Liability (auto accidents)	8	157
Compensation (workmen)	119	1,322
Asso. Hosp. Service Plan	866	8,667
Service (part pay)	463	5,006
Town	266	3,263
State	96	1,477
Endowed Rooms and Beds	21	385
Free	132	1,226

We are most grateful to the Community Chest who made it possible to purchase a bookkeeping machine which gives the hospital an opportunity to conduct its affairs in a more efficient manner, as more detailed accounting has been made possible with additional information. This year, for the first time, we have been able to record the value of the free work which amounted to \$27,457.43.

Meriden Hospital

School of Nursing Issues A Call To Service

To Graduate Nurses of Meriden and Surrounding Communities:

How many times during the past six months have you picked up a newspaper and found a thrilling account of the wonders performed with the new drug sulfanilamide and thought, "I wonder how that drug acts?" How many times have you read of oxygen and serum therapy being used in the treatment of pneumonia and said to yourself, "I wish I knew more about these things." When reading of the National Defense Program have you wondered "what responsibilities will the Nursing Profession have to assume?"

As never before in our history nurses are needed in every community to conserve the health of our people and care for the sick. In case of national emergency professional nurses will be urgently needed. The Meriden Hospital School of Nursing is, therefore, offering a "Refresher Course" to professionally trained nurses presenting the newer trends in general medicine, nursing procedures and technics. Our primary purpose in giving the course is to enable the now inactive nurse or the nurse caring for the chronically ill to resume active service again. This course is not designed to be a post-graduate course, but we do hope to make it a help to the graduate who would like to "brush up" so

that she may give more effective assistance to the profession in meeting the demands of today.

Milford Hospital

Due to a typographical error, an item regarding the Milford Hospital was presented in last month's issue as part of the Meriden Hospital.

The year 1940 showed a general increase in all services. At times all private and semi-private rooms were filled and there was a waiting list.

	1940	1939
Daily average number of patients	31.1	24.5
Number of accidents	338	245
Number of births	161	144
Number of operations	295	290

Funds will soon be available from an estate left the hospital. This will allow the building of an addition which will give more private and semi private rooms and also rooms for isolation of ward pneumonia and noisy or very sick patients.

New Haven Hospital

If our members have not seen the new bulletin put out by the New Haven Hospital, they should all write to our friend, Mr. James Hamilton, Superintendent, and secure a copy.

Norwalk General Hospital

From the Norwalk Hospital Bulletin:

"Hail to the youngest member of the Hospital Family—the Baby Alumni Association—sponsored by the Woman's Board. All babies born in the Norwalk Hospital are eligible for membership and it is hoped that many children will enroll in the Book of Honor.

"The funds of the association will be used to aid those babies and children who are in need of special care and to buy new equipment for the nurseries, thus permitting better care in future years.

"Though the association is new to Norwalk, it follows a well tested idea used by many other hospitals, which say that their Baby Alumni Associations are lusty infants and prized members of the family.

"It is expected that the new association will have a steady growth in membership as the months go by. All of the other members of the family, the Hospital Association, the Board of Directors, the Woman's Board, and the Hospital Volunteers, extend greetings to the new member and wish her great success and happiness."

TUMOR CONFERENCES

"Dr. W. C. Stone, Director of the Tumor Conference, states:

"We have just concluded the fifth year of work. The number of patients remained almost stationary. The chief interest of the local medical profession in this work is among the younger members. With few exceptions, the patients are referred earlier in the course of their disease than they were formerly."

"We are now officially recognized by the College of Surgeons as an approved department of the hospital."

Minutes of the Meeting of the Trustees

January 24, 1941

A meeting of the Board of Trustees of the Connecticut Hospital Association was held at the Hartford Hospital on the above date with President Wilmar Allen presiding. Members present: Miss Griffin, Miss Nivison, Messrs. Bartine, Davidson, Buck, Sweeney, also Doctor Henry Mason and Mr. Brosmith of the Public Relations Committee.

The Secretary read an announcement of the annual mid-year conference of the American Hospital Association at Chicago on February 15 and 16 with the request that the President and Secretary of the State Association attend as delegates.

Voted: To appoint the President as a delegate with the Secretary as an alternate to represent the Connecticut Hospital Association at this conference with expenses paid by the Association.

The Secretary announced his appointment by the Council on Association Development as field representative of the American Hospital Association for Connecticut and his acceptance of the same.

Mr. Bartine, Chairman of the Public Relations Committee, read a communication from Mr. Todd of the Bradley Memorial Hospital at Southington concerning the regulations of the State Liquor Control Commission covering the filing of Tax Exempt Permits on each withdrawal of alcohol. The Trustees at the discussion referred the proposition to Judge Thomas for advice and action.

Voted: To authorize the Treasurer to forward a check in the sum of \$500.00 to Attorney Thomas as annual Retainer Fee.

A letter was read from the National Association concerning the membership status of Mr. Hinsley.

Voted: That Mr. Hinsley's name be dropped from the membership role because of dues unpaid and nonresidency in this state.

The report of Doctor Geeter's Committee on Compensation Rates which had been distributed to the members prior to the meeting was presented for discussion. No formal action was taken pending reports from member hospitals.

The problem of deferment for internes before local Draft

Boards covering the appointments for 1941-42 was presented by the Chair. Discussion followed.

Voted: That the Secretary be empowered to draft a letter in conjunction with the Secretary of the State Medical Society, said joint letter to be signed by President of the Association relative to action for deferment of internes, and that copies be furnished to member hospitals for forwarding to their respective Draft Boards supplementing the action of their own Board of Trustees.

The Chair submitted an invitation from the State Medical Society for participation in the next State Clinical Congress. The Secretary was authorized to notify Chairman, Doctor Louis Nahum, c/o Grace Hospital, New Haven, that due to a conflict in dates with the American Hospital Convention it would not be feasible to plan for such participation.

Doctor Buck gave a report summarizing the action of the joint Defense Council meeting held the previous day. The following committee reported for the State Association: Doctors Buck, Allen, and Glazier and Miss Griffin. The possibility of a State Defense Council including all phases of emergency control was outlined, also brief sketches were given of the present Waterbury, New Haven and Willimantic plans which have already been proposed by their respective areas. The major problem of extra beds and linen was discussed in detail.

In view of the proposed establishment of a State Council by the Legislature, it was deemed advisable to await its organization. Member hospitals are to be advised in the meantime to give immediate consideration to their individual problems pertaining to defense and gained data for further report.

Voted: That Mr. Richard Hancock, Manager of The Lawrence and Memorial Hospital in New London, be appointed State Chairman for Connecticut for National Hospital Day, 1941.

Mr. Bartine, Chairman of Public Relations Committee, read a letter from Mr. Hancock of the Lawrence and Memorial Hospital stating that the Trustees of the hospitals in eastern Connecticut had recently organized an Association and had appointed a Legislative Committee that desired to cooperate with the State Hospital Association in its legislative program. The Committee consists of the following: Mr. Charles A. Saxton, President, Backus Hospital, 274 Broadway, Norwich; Richard E. Dodge, President of The Windham Community Memorial Hospital, Inc., Willimantic, Conn. (Storrs); Mr. Ward T. Alling, Director, Lawrence and Memorial Hospital, 240 State Street, New London.

Secretary Sweeney outlined to the Trustees, briefly, the plan of the Eastern Connecticut group stating the desire of this body to promote a more intensive interest on the part of the Trustees and to cooperate with the State Association in every phase of hospital work and especially in any proposed legislative program.

Voted: To invite the above Special Committee to become members of the State Hospital Association Committee on Public Relations and authorize the Secretary to extend an invitation to the entire group to join as personal members of the State Hospital Association

Bills were presented by the Treasurer and ordered paid.

Chairman Bartine reported, following the recent action of the State Convention, that he had referred the special House Bill pertaining to increased grants, to the Association's legal council who had approved the same without change with the statement that in his opinion this bill did not in any manner endanger the present appropriation to any member hospital and should be the only bill introduced by the Association for additional State support this year.

Voted: To adjourn at 3:55 P. M.

Attest:

William B. Sweeney, Secretary.

An Act Concerning Appropriations to Hospitals and Hospital Rates

We present herewith the bill which was spoken of in the minutes of the Trustees' meeting and which was endorsed by the Assembly at its annual meeting subject to approval of the Association's council. Judge Thomas, after consideration of the question raised by Mr. Sweeney. It will be noted in the minutes of the Trustees' meeting that Judge Thomas, in rendering his opinion, stated that the bill did not in any manner endanger the present appropriation to member hospitals.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 90d of the 1937 Cumulative Supplement, is amended to read as follows:

"Appropriations to hospitals. All appropriations to hospitals by the general assembly shall be expended under the direction of the governor and of the managers of such institutions, respectively, for the support of charity patients, and so used as to benefit the state as application may be made from time to time, a report of which expenditure shall be made biennially to the general assembly; but no part of such appropriations shall be paid to any of such hospitals unless the same be in actual operation, unless the purpose for which an appropriation is to be expended is for a building and is so specified in the act making such appropriation. No such hospital shall charge or receive more than eight dollars per week for the care of any patient when such expense is to be paid by the state, either directly or through the agency of any town therein, *provided, however, that if the total of the expense incurred by the state for such care during any fiscal period at said rate of eight dollars per week plus the annual appropriation by the general assembly to such hospital shall not be sufficient to pay such hospital for such care at the rate of five dollars per day for each such patient, such hospital shall be paid the deficiency by the state within ninety days after the close of said fiscal period.*"

MEDICAL PREPAREDNESS SECTION

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic

George M. Smith, M.D., State Chairman, 258 Church Street, New Haven, Conn.

Changes in Selective Service Personnel

L. H. Nahum, New Haven, additional Consultant in Internal Medicine. New Haven Advisory Board.

H. C. Little, New Haven, additional Consultant in Ophthalmology, New Haven Advisory Board.

R. H. Jenkins, New Haven, Consultant in Urology, New Haven Advisory Board.

F. S. Jones, Hartford, additional Consultant in Orthopedics, Hartford Advisory Board.

C. H. Neuswanger, Waterbury, Consultant in Urology, Waterbury Advisory Board.

H. B. Kneale, Bridgeport, Consultant in Urology, Fairfield County Advisory Board.

J. F. Brosnan, New London, Consultant in Urology, Norwich Advisory Board.

Harold Strickland, Meriden, additional alternate Examiner, Board 13A.

H. F. Morrill, Waterbury, alternate Examiner, Board 15A to replace A. E. Herrmann.

H. N. Rasmussen, Uncasville, additional alternate Examiner, Board 20A.

Connecticut Physicians Ordered to Active Duty

*Samuel H. Cohn, Hartford.

*James E. Crane, Stamford.

*George C. LaTaif, New Milford.

Wendelin C. Luckner, Stafford Springs.

*Bennie A. Moxness, Hartford

Charles K. Skreczko, Shelton.

Previous Orders Revoked

Alan A. Rozen, New Haven.

*Members Connecticut State Medical Society.

Draft Board Examinations by Mass Production

FREDERICK W. ROBERTS, M.D.

Medical Examiner Board 11A, New Haven

To facilitate the work of draft board examiners, and to have available a method by which large numbers of men can be quickly and efficiently examined, a mass production system was recently inaugurated at the New Haven Hospital.

Four boards coöperated. The New Haven Hospital contributed the use of the outpatient department for this purpose. In the waiting room was stationed a policeman and a clerk, appointments were made throughout the afternoon, allowance being made for draftees being late. The regular notification cards were taken on arrival and draftees directed in order to the first room where four tables were arranged, one for each board. Medical student volunteers recorded the histories and had the draftees sign their names. Duplicate copies of the records were retained by the secretary of each board. The Wassermann slips were made out in advance by the secretary of each board, signed by the examiner and clipped to the record. If the historian found that the draftee had a history of venereal infection, a red tag was put under the clip. Five minutes was allowed for taking the history. In most instances about three minutes was sufficient.

After completion of the history the draftee was sent to the next room where three dentists examined the teeth and recorded the findings.

At a third station three eye specialists tested the eyes.

Following examination of the eyes, a check room was arranged where the men removed their coats and rolled up one sleeve.

The next station was a desk outside the lavatory where a student wrote the draftee's name on a slip held by an elastic on a specimen bottle. He was then

directed to void a specimen in the lavatory and take it to the laboratory in an adjacent room.

At the entrance to the laboratory was a nurse who collected the record, and a technician who collected the specimen. Three hospital technicians were used to examine the urine while the draftee was in the room having the blood taken for the Wassermann. The report of the urinalysis was written on the slip attached to the bottle and returned to the nurse at the table who copied it on the record. Three doctors were stationed in the laboratory at examining tables to take blood samples. Each doctor was assisted by a nurse. Fifty syringes were used and a circulating nurse washed the used syringes and resterilized them for future use. The Wassermann bottles were removed from the containers in advance and after blood was obtained the draftee was given the bottle with his blood to return to the nurse at the desk who put it into its container, and if there was no red tag on the record the container was put in a large carton to mail directly to the State Laboratory at Hartford. If there was a red tag, the draftee was asked to take specimen with slip along to the medical examiner.

The draftee was then given his record with urine recorded and asked to go to the suite of rooms assigned to his board. Large signs were made with the number of each board to direct him to the proper suite. Each suite had four adjoining rooms. In the first room the man undressed and was weighed, measured and physical characteristics recorded by a student. He then went to one of the examiners for the completion of the physical examination and classification. In some instances one or two extra examiners were used to assist in the work.

When all the examinations are completed the examiner of each board collects the records from his assistants, checks their classification, and returns them to his board.

The team was made up of nine students, three dentists, five nurses, three technicians, eighteen doctors, including three eye specialists and three doctors for collecting blood samples, two clerks and one policeman.

The production capacity is 72 per hour. The examination of each draftee requires thirty minutes. On January 4, 224 men were examined in three hours and ten minutes. By this method three, three hour sessions will complete a 20% quota for four boards.

The success of this organization was mainly due to the willingness and spirit of the people who were asked to coöperate.

Conference on Civilian Preparedness

A unique and rather unusual group met for the discussion of civilian preparedness at the Hunt Memorial Building in Hartford on January 23. Doctor Arthur B. Landry, President of the State Medical Society, presided and those present included the following: S. H. Wadhams, M.D., Chairman Joint Executive Defense Committee, State of Connecticut; S. H. Osborn, M.D., Commissioner of Health; G. M. Smith, M.D., Chairman Committee on Medical Preparedness, State Medical Society, and H. B. Lambert, M.D., Bridgeport, D. B. Wells, M.D., Hartford, F. A. Sutherland, M.D., Torrington, C. C. Harvey, M.D., Middletown, R. E. McDonnell, M.D., New Haven, D. Sullivan, M.D., New London, D. G. Beckwith, M.D., Rockville, all members of the same committee; C. Barker, M.D., Secretary State Medical Society; J. D. Gold, M.D., Bridgeport, President-elect, State Medical Society; S. B. Weld, M.D., Editor of the Journal; J. I. Linde, M.D., Health Officer, City of New Haven, A. J. Jackson, M.D., Waterbury; W. M. Allen, M.D., Hartford, President Connecticut Hospital Association; A. W. Buck, Chairman, and Miss A. M. Griffin, member Hospital Association Committee on Preparedness; Miss Marion Douglas, Hartford, Miss Agnes Ohlson, Hartford and Miss Elizabeth Fox, New Haven, members of State Nurses Association; and from the American Red Cross, R. A. Shepard, Washington, D. C., J. H. White, Danbury, Pomeroy Day, Hartford, Clayton Shores, New Haven, P. W. Franklin, Norwich, Elmer Spaulding, New London, H. B. Spelman, Fairfield, W. C. Kennedy, M.D., Torrington, Miss Hazel Dudley, R.N., Hartford, and H. D. Gallaudet, Torrington.

The Conference disclosed the various programs of preparedness being undertaken by the organizations present and served to inform those present of what had been accomplished and what was contemplated in the immediate future. Many were unfamiliar with the picture as a whole and by this exchange of opinions and plans were able to inform their own organizations of latest developments in defense in Connecticut.

General Wadhams presented very clearly the work of the State Defense Committee from its origin

in 1939 to date. Doctor Osborn outlined the problems being dealt with by the American Medical Association in assisting the government in the functioning of the Selective Service Act. Doctor Barker outlined the three functions of the State Medical Society, viz., (1) the selection of physicians to serve under the Selective Service Act, (2) the selection of physicians for the Army, and (3) civilian medical care and disaster relief.

Doctor Buck of the Charlotte Hungerford Hospital presented detailed hospital plans for meeting emergencies. Miss Douglas emphasized the fact that the State Nurses Association constituted a supplementary service to the medical profession and planned to fit its program of defense into that of the State Medical Society and the State Hospital Association.

Considerable discussion of Red Cross functions and plans occupied part of the conference. Mr. Shepard reported from National headquarters, Mr. Day presented Hartford's plans, and Doctor Linde edified all present with a complete plan for city defense as set up in New Haven. The work of First Aid classes in Torrington and Waterbury factories was outlined by Doctors Kennedy and Jackson and this, in turn, led to a discussion of the First Aid courses as they are being carried out in some of the cities, notably New Haven.

Medical Expense Fund of New York, Inc.

Because of its implications the situation pertaining to medical expense and voluntary health insurance in New York should interest the entire medical profession. Through the efforts of Supreme Court Justice R. Foster Piper, retiring as chairman of the joint legislative committee on revision of the insurance law of the New York State Legislature, provision was made by the 1940 Legislature for the development of plans of medical expense insurance. Unfortunately, however, the law did not limit or specify the number or kind of corporation which might attempt to qualify under Section IX-C, except that such a corporation must operate on a non-profit basis. As a result of this loose wording of the law a large number of corporations were allowed to enter this business and at the present time it seems obvious that this will result in the lack of growth of some, if not all of them, and the possible failure of some, if not all, with resultant discredit to the whole idea.

Justice Piper has warned that if a system of voluntary medical expense insurance is not established, the proponents of compulsory health insurance will come into control. Assemblyman Robert F. Wagner, Jr., New York City, has already introduced into the 1941 Legislature the Epstein bill for compulsory health insurance. To prevent chaos developing out of the present situation the Medical Society of the County of Westchester, through its Committee on Medical Economics, has carefully studied the plans of the six organizations established under Section IX-C of the Insurance Law and reached the conclusion that Medical Expense Fund, of New York, Inc., is the only such plan which should be approved. This plan is so organized that the medical societies of the Metropolitan Area effectively control its policies through their duly elected delegates who are the voting members of the corporation. This plan seems to contain the fewest objectionable features, to be the soundest, most reasonable and fairest both to the patient and to the physician, and to give promise of being most likely to succeed since it follows most closely the established pattern of medical practice and accepted principles of insurance.

Physical Therapy in Chronic Arthritis

Physical therapy is one of the most important measures available to the physician in the management of chronic arthritis. In view of the highly intricate nature of much of the treatment, it should not be undertaken by the general practitioner in his office if he is located in a community where special facilities are available. A good many years' experience have taught me the important lesson that if the best results are to be obtained, treatment must be supervised by a master of the subject who has devoted years of his life to the application of these various implements. It is a pity that so many amateurs have invaded the field. Every effort should be made to curtail their activities and to permit only those well qualified to practice this specialty. Though I treat a great many patients with arthritis, I have never had any physical therapy equipment in my office, having always felt that in all fairness it should be used by a specialist. By following this rule, I have rarely been disappointed in the results obtained in my patients.

R. S. Cech, M.D.,
Arch. Phys. Ther., Oct. 1940.

CONNECTICUT MEDICAL SELECTIVE SERVICE

WILLIAM B. SMITH, MAJOR, M.C., *State Medical Officer*

This the first of a series of articles explaining the development, operation and results of medical selective service in this State

OUR NATIONAL SELECTIVE SERVICE system has been operating for about five months. During that time in Connecticut there have been examined approximately 12,000 men. It is time that we consider some of the results which, while not yet conclusive, will have been definite enough to show the general trend of physical and mental impairments within our State. We have also in these five months accumulated experience in executing this kind of service, which experience, if carefully studied, will be of value for the duration of this Selective Service Act and for further emergencies.

When the Selective Service Act became operative, Connecticut, like the other states, was faced with the problem of organizing the medical profession for volunteer duty. The problem involved the medical profession, so it was felt by the Headquarters Staff that the Connecticut State Medical Society should handle the selecting and suggesting of eligible physicians for this type of duty. The Society was contacted.

Within the Connecticut State Medical Society there is a Committee on National Defense. This Committee consists of a chairman and eight members, each one of the eight members representing his respective County Medical Association. In fact, each one is the Chairman of his respective County Medical Association Committee on National Defense. Therefore, it seemed logical to call upon this State Committee for assistance in the selection of physicians for Selective Service. After the proper groundwork was done, the State Medical Officer for Selective Service met with the Committee and outlined the specifications for the appointment of physicians for the Selective Service System in Connecticut. Through the Secretary of the State Medical Society, each physician whom it was found desirable to appoint was contacted and asked whether or not he would serve if he were appointed. In this same letter he was given a memorandum of the type of work expected, the approximate amount, etc., for it was felt that he should know when he

volunteered his services just what such an act on his part would mean. When the acceptances were received by the office of the State Medical Society, they were compiled for each of the sixty-five Boards in the State, and the list was inspected by the State Medical Officer. Upon his recommendation to the Director of Selective Service for Connecticut, this was sent to the Governor through whose office the proper appointments were made.

In the same fashion the members of the five Medical Advisory Boards in the State were selected. In the case of these men, however, it was specified that insofar as it was possible every member should be certificated in his field of specialty. In almost every instance it was possible to comply with this desire.

In setting up this system in Connecticut it was necessary to select men from the dental profession. The same plan has been followed in selecting these men; namely, enlisting the services of the Connecticut State Dental Association. This Association made all recommendations and completed the groundwork, as in the case of the State Medical Society, and the dental surgeons were then properly appointed through the office of the Governor.

The above program constitutes the selection and appointments of physicians according to the Regulations of the Selective Service Act.

The State Medical Officer in Connecticut must supervise and coördinate the work of all the physicians in the State engaged in selective service. To do this singlehanded and to keep up the work at Headquarters would be an impossible task. He, therefore, has again gone to the Committee on National Defense of the State Medical Society and has asked the eight chairmen representing the eight counties in the State to assist him in coördinating the work. The word "coördination" is emphasized in that they are not asked to do any work of a supervisory nature. It must be remembered that these men are not appointed according to Selective Service Regulations. Their connection with this system is simply as chairmen of the Committees on National Defense for the respective counties in which they reside. The State Medical Officer, however, finds the help of these eight chairmen very

beneficial, and hopes through his connection with the Selective Service Headquarters that he may enjoy their confidence and coöperation.

In accordance with Selective Service Regulations, the local physicians on any Board may refer questionable cases to clinical laboratories or x-ray departments for further study. In view of the fact that there would be a wide diversification in charges for this work, and considering the fact that these laboratories and hospitals were asked to participate in an entirely new system, the State Medical Officer believed that their coöperation should be sought and that a uniform fee for examinations should be set by all such laboratories and hospitals. In order that there might be some standardization of the reports and results of such examinations and x-ray work, it was believed that because of the geographical location of the general hospitals in the State all such work should be limited to these institutions. If the facilities of private laboratories were enlisted, such a procedure might result in confusion and embarrassment, over which the State Medical Officer would have no control. Therefore, a circular letter was sent to some thirty hospitals, all members of the Connecticut Hospital Association, asking them to set a fee for the type of examination requested, and this action resulted in the inviting of the State Medical Officer to confer with the Connecticut Hospital Association at its semi-annual meeting on November 22, 1940. This resulted in a satisfactory schedule of fees.

With regard to the serological tests required under the Selective Service Regulations, the Headquarters Staff was of the opinion that this could be carried on best by the Connecticut State Department of Health through its Commissioner. He was contacted and asked whether he would assume the responsibility of furnishing containers, doing the serological tests, and forwarding the reports to their proper destinations. He assigned one of the physicians in his department to work with the State Medical Officer in this respect, and this has proved to be satisfactory. One of the details of this arrangement might be interesting. When the State Department of Health finds a man's blood to be negative, one report is sent directly to the Local Board which, in turn, copies the findings on the physical examination form. If, however, the specimen is positive, the report is sent directly to the State Medical Officer, who arranges for the second Wasserman to

be done. Instead of asking the local physician to take the second Wasserman, the registrant is sent to the Health Officer in the town in which he resides, and the latter takes the test and forwards the specimen to the Connecticut State Health Department. When the second positive is received, the State Medical Officer forwards both reports to the Chairman of the Local Draft Board in the regular Selective Service envelope, but marked "Confidential." He asks the Chairman of the Board personally to copy the findings on the physical examination form.

The following constitutes the several groups and agencies which make up the Selective Service Medical Staff in Connecticut.

1. The State Medical Officer (Headquarters).
2. Local Board Examiners and Alternates.
3. Medical Advisory Boards.
4. Connecticut State Department of Health.
 - a. Bureau of Laboratories (serological tests).
 - b. Bureau of Mental Hygiene (neuro-psychiatric tests).
5. Connecticut State Hospital Association.
 - a. X-ray examinations.
 - b. Clinical examinations.
6. Connecticut State Medical Society.
7. Connecticut State Dental Association.

The Tuberculosis Commission for the State of Connecticut suggested that the chest of every draftee be x-rayed in order to detect pulmonary pathology which would be detrimental to a man in Army service. A representative of that department and the State Medical Officer and the Director of Selective Service spent considerable time in an endeavor to work out a system whereby every man could be x-rayed before he reached the induction line. So many obstacles were encountered that it was finally agreed that such a plan would be impracticable. A good substitute for such an abandoned plan, however, was to examine each man as he passed through the Army induction line. If he were inducted into service before the plates could be read and he were found to have pulmonary pathology, he could again be discharged from the Army or, at least, placed in a sanitarium, even though he were in service. Happily, however, Doctor Paul Phelps was so successful with this experiment at the time of the first induction line in reporting the findings before the man was inducted, that the Army has been very coöperative in setting

up apparatus as a permanent feature of that line. Hence, a number of cases has been rejected because of pulmonary pathology before induction into service.

In order to carry out the regulations of the Selective Service Act so far as medical selection is concerned, it has been necessary to pay a considerable attention to the neuro psychiatric phase of this work. The Connecticut psychiatrists have been very helpful in their suggestions, and a practical system of detecting men with neuropsychiatric background has been devised through the efforts of these specialists. The work has fallen directly upon the Connecticut State Department of Health as it has in the case of serological tests and that Department has risen to the occasion most admirably through its Bureau of Mental Hygiene. More about this in detail will appear in another issue.

A discussion of the organization would not be complete without some mention of the part played by the dental profession. One of the greatest stumbling blocks in the selection of men has been the necessity of properly surveying and classifying the teeth. This has not been a minor difficulty. Therefore, the State Dental Association has been called upon and has offered its good offices in helping to select at least one dentist for each group of medical examiners or for each board. This has made our physicians very happy and certainly has facilitated the selection of these men in such a fashion that now we note a decided reduction in the percentage of rejections at the time they are examined for induction into the Army.

THE DOCTOR'S OFFICE

Doctor Harold E. Speight announces the re-opening of his office for the practice of Internal Medicine, 642 Main St., Middletown.

Doctor Sidney H. McPherson announces that Doctor Burr N. Curtis will become associated with him in the practice of Orthopedic Surgery, February 1, at 4 Atwood Street, Hartford.

Doctor A. Frederick Serbin announces the opening of his office at 99 Pratt Street, Hartford, Traumatic and Orthopedic Surgery.

THE FORUM

The Forum has appeared in each issue of the JOURNAL for over a year. Although it is the work of one member of the State Medical Society, it was originally intended to offer a column for the publication of any facts of interest from any physician's handbag. It is the hope of the Editor that this column may yet serve the purpose for which it was created

An interesting experimental work is being accomplished by Raab of the medical faculty at the University of Vermont. Working on the theory that angina of effort is caused by a discharge of epinephrine into the blood stream, he has been treating the syndrome with x-radiation to the adrenals. His original series of 100 cases treated in Vienna has already been published in the *Journal of Internal Medicine* for October 1940. These results were so favorable that he resumed his experiments after he became associated with the University.

With experience and a better selection of cases, the results in a new and unpublished series have been even more impressive. The treatment has been standardized and has been proved relatively harmless. The technique is as follows: All cases that are classified as angina of effort are given a preliminary test by injection of 2 or 3 minims of epinephrine. If the pain appears and one must be prepared to treat the acute synipnyoms, the case is listed as suitable for treatment by x-radiation. This is given in doses of 200 R to each adrenal on alternate days for six doses or in other words one adrenal is treated daily. There have been no unpleasant side effects even in those cases that had two or three series of treatments. The remote effects are still incompletely known, but have been favorable.

One interesting sidelight of this treatment has been observed. Several of the cases were also suffering from bronchial asthma and following this treatment they had no further difficulty with this condition. The investigators have no explanation for this phenomenon which seems to controvert the known fact that epinephrine does relieve an attack of asthma. More research is being done on this.

A cursory check of the physical findings on

approximately 300 of the current crop of draftees reveals two stand-out items: 1—The teeth and gums of these young men are in a bad way and 2—they have a marked vasomotor instability as evidenced by their blood pressure and pulse readings.

The condition of the mouth is important not only because it is a health hazard but also because it reduces the manpower available for training. Almost half of the rejections have been due to this one cause. While it is true enough that the government, because the induction period is limited to one year, will not assume the responsibility for the care of these individuals, the problem still remains with the dental and medical professions.

The vasomotor instability has had little effect on the rejection list except in proven cases of hypertension. However it promises well for the future, as it is a vast reservoir of potential cardiovascular-renal and mental disease. It can well be that army training may stabilize these young men, but the history of the last world war does not confirm that opinion. That this is not a purely local finding has been checked by preliminary reports from other communities, and in some localities the professions are already taking steps toward finding a solution.

Many years ago Luther Burbank wrote "Mental evolution is the reaching of man toward more and more freedom from outside aid and the steady growing toward a better mental and moral fiber from within himself." How important these words seem is never more apparent than after the daily bouts with the "nervous" man, the "nervous" woman and the inevitable "nervous" child. Mental hygiene is just beginning to gain a foothold in our scheme of things. When it does come of age it will go a long way toward achieving that goal.

T. P. R., M.D.

OUR NEIGHBORS

New Jersey

Announcement is made of the recent formation of the New Jersey Society of Physical Therapy Physicians, at the Academy of Medicine of Northern New Jersey. Monthly meetings will be held during the winter season in different centers in the State.

New York

The New York State Journal of Medicine, January 15, 1941, contains a very complete and illuminating article on "A Study of County Society Activities", the contents of which are worth the perusal. If any physician in Connecticut believes his County Association dues are unreasonably large, exorbitant, or unnecessary he would do well to compare them with those existing in many counties in New York State. Ten County Medical Societies in that state collect annual dues from their members of over \$5.00 and five of these run over \$10.00. Westchester County, which maintains one of the most active and effective medical societies, heads the list with annual dues from \$12.50 to \$25.00. The writer is convinced "that the time has come when a society secretary must be able and willing to devote more than a few spare minutes to his duties if the society is to retain its importance and live up to its responsibilities as a component of a large, influential State Society." The State Society, on the other hand, should take a lively interest in the activities of the county societies, aiding them in problems which are not geographically limited to any one society.

YOU ASKED FOR IT: — The Professional Equipment Company of New Haven announces that they have a new Taylor Pavaex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

LEGISLATIVE SECTION

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

BERKLEY M. PARMEELE Bridgeport	D. C. Y. MOORE S. Manchester	HARRY B. HANCHETT Torrington	JOSEPH A. BEAUCHEMIN Middletown	GEORGE BLUMIER <i>A.M.A. Delegate</i>
DAVID R. LYMAN Wallingford	EDMUND L. DOUGLASS Groton	RALPH B. THAYER Somers	CECIL R. GARCIN Danielson	JAMES R. MILLER <i>A.M.A. Delegate</i>
ARTHUR B. LANDRY, President			CREIGHTON BARKER, <i>Executive Secretary</i>	

Bills Submitted to the 1941 General Assembly That Have to do With Medicine, Health, and Welfare

Committees to which measures have been referred are noted in parenthesis

ABBREVIATIONS

Ag.—Agriculture.
App.—Appropriations.
C.A.—Constitutional Amendments.
C.B.—Cities and Boroughs.
Edu.—Education.
F.R.—Federal Relations.
H.I.—Humane Institutions.
Inc.—Incorporations.
Jud.—Judiciary.
M.V.—Motor Vehicles.
P.H.S.—Public Health and Safety.
S.A.—State Administration.

SENATE BILLS

- S. B. 26. Provides commitment to Long Lane Farm of any unmarried girl between sixteen and eighteen who has been adjudged by any court to be in danger of falling into habits of vice. (Jud.)
- S. B. 28. Establishes a compulsory and exclusive workmen's compensation fund. (Jud.)
- S. B. 34. Concerning a board of examiners in massage. Defines the art of massage, establishes standards, methods of licensure for masseurs and penalties for violation. (S.A.).
- S. B. 35. Creates a State Department of Mental Health consisting of a State Commissioner of Mental Health and a department with a council of ten. (S.A.) (Introduced by the Connecticut Society for Mental Hygiene.)
- S. B. 36. Supplementary bill to 35. Provides for approval of the Commissioner of Mental Health of physicians examining persons for commitment. (S.A.)
- S. B. 37. Supplementary bill to 35. Provides for licensing of institutions by the State Department

of Mental Health by amending Section 682c and 576c. (S.A.)

- S. B. 62. Provides for the establishment of a state compensation insurance fund in the Department of Labor and Factory Inspection and requires that all compensation insurance now required by law shall be carried by such fund. (Jud.) (See S. B. 28.)
- S. B. 65. Blood and urinal test in the case of arrest for driving under the influence of alcoholic liquor, providing that any person arrested may make such demand and the findings of the analysis shall be admissible as evidence. (Jud.)
- S. B. 79. The establishment of a Division of Industrial Health providing for the transfer of the Bureau of Occupational Diseases from the Department of Health to the Department of Labor and Factory Inspection, to be known as the Division of Industrial Health to investigate industrial establishments and work places within the State with reference to the health of employees. (P.H.S.)
- S. B. 125. An act concerning medicine and surgery, providing for the amendment of Sections 2741, 2742, 2747, 2749. (State Society Bill.) (P.H.S.)
- S. B. 158. An act concerning appointment of pupils to schools for the deaf. (Edu.)
- S. B. 159. Concerning the charter of the American School for the Deaf at West Hartford. (Edu.)
- S. B. 180. Concerning the licensing of institutions for the care of the insane. (Jud.)
- S. B. 183. Concerning the admission of insane persons to hospitals on certificates. (Jud.)
- S. B. 209. Concerning appropriations to hospitals and hospital rates. (Jud.)
- S. B. 210. Concerning examinations for State employees. (Jud.)
- S. B. 220. Concerning safety regulations for workmen in building operations. Provides minute

- regulations regarding construction of scaffolds, safeguards and devices in building operations. Fixes responsibility for maintenance, storage of explosives, blasting operations, working under compressed air, hoisting machinery, etc. (Labor.)
- S. B. 223. Concerning abolishing the Mystic Oral School for the Deaf. (P.H.S.)
- S. B. 224. Concerning the qualifications of the Commissioner of Health (P.H.S.)
- S. B. 225. Concerning the Tuberculosis Commission. (P.H.S.)
- S. B. 226. An act to prevent spread of tuberculosis by recalcitrant or rebellious patients who are a menace to the public health. (Blank bill.) (P.H.S.)
- S. B. 227. Concerning a commission on the care of the chronically sick and infirm. (P.H.S.)
- S. B. 228. Concerning a custodial care institution at Mystic under the administration of the Norwich State Hospital. (P.H.S.)
- *S. B. 230. An act amending an act concerning the uniform state narcotic and drug law. Amends Section 919e providing for conservation of supply of opium on hand so there will be ample supply for legitimate use. (P.H.S.)
- S. B. 231. Concerning an appropriation to the State Department of Health for the Study of Cancer and the maintenance of clinics. (P.H.S.)
- *S. B. 233. An act amending an act concerning sanitary districts. Amends Section 2376, General Statutes, as amended by Section 929c providing for the creation of district departments of health when approved by the Commissioner of Health. (P.H.S.)
- *S. B. 234. Cremation. Amending 2399 of the General Statutes as amended by Section 1045e providing that forms shall be provided by the State Department of Health rather than the Bureau of Vital Statistics. (P.H.S.)
- *S. B. 235. Concerning approval of water and sewerage systems. Providing for filing with the State Department of Health of plots of land subdivisions showing proposed method of handling water and sewerage; department may order submission of plans. (P.H.S.)
- S. B. 236. An act incorporating the College of Natureopathic physicians. (P.H.S.)
- S. B. 241. Concerning a Council on Mental Health. (S.A.)
- S. B. 442. An act amending the charter of the Greenwich Hospital Association. (Inc.)
- S. B. 495. An act concerning the administration of workmen's compensation providing for administration and enforcement of the act to be vested in the Department of Labor and Factory Inspection on and after July 1, 1942. Division of workmen's compensation created, composed of the workmen's compensation commission and all employees now engaged in enforcement of the act. (Jud.)
- S. B. 504. An act concerning hours of labor of employees in State institutions providing for a maximum of eight hours a day for any non-professional employee or nurse in any State institution and for a maximum of forty-eight hours a week except in the case of an unavoidable emergency. (Labor.)
- S. B. 517. An act amending an act concerning the licensing of hospitals, amends Section 2391 of the General Statutes, providing that the provisions of this Section shall not apply to institutions wholly supported by the State, or to any institution partially supported by the State that meets the requirements of the American College of Surgeons. (P.H.S.)
- S. B. 519. An act concerning osteopathy. (Blank Bill.) (P.H.S.)
- S. B. 520. An act concerning nursing. Providing for amending Section 999e by substituting July 1, 1941 for July 1, 1940 and amending Chapter 158 by adding further requirements for those eligible for examination for certification as an industrial attendant. (P.H.S.)
- S. B. 529. Concerning health insurance. Introduces the model health insurance bill of the American Association of Social Legislation. (S.A.)
- S. B. 745. An act concerning persons who are mentally ill, providing for substituting words "mentally ill" for "insane" whenever it appears in Chapter 88 of the General Statutes and substituting "hospital for mental illness" for "asylum" in said chapter. (Jud.)
- S. B. 751. An act concerning appropriation for hospitalization and medical provision for the poor. (Blank bill.) (Jud.)
- S. B. 753. An act concerning commitments—Section 1791. Provides for amendment of said Section by allowing the commitment of habitual drunkards and those addicted to narcotics to a hospital

- for a period of not more than ten days without order of any court if a physician's certificate has been sworn to and delivered stating that the person is in need of treatment and the reason therefor. (Jud.)
- S. B. 761. An act concerning the detention of insane persons, providing for detention of insane persons for not more than thirty days without the order of a court of probate upon a signed and sworn certificate of a physician. (Jud.)
- S. B. 772. An act concerning coroners and State's Attorney's. Providing for consolidating offices of coroner with that of State's Attorney in Hartford, Fairfield and New Haven Counties and for appointment of chief assistant and assistant State's Attorneys who shall not engage in other practice of law. (Jud.)
- S. B. 776. An act concerning physical examinations for State employees providing for examinations every six months if employee is in contact with contagious diseases. (Jud.)
- S. B. 780. An act concerning the appointment of coroners for each county in the State, providing for appointment of coroners and deputy coroners to receive equal salaries and fees. (Jud.)
- S. B. 818. An act concerning a State Council of Defense. Providing for a national and State defense, the establishment of a State Council of Defense and of local and district Councils of Defense and prescribing the powers and duties thereof. (Military Affairs.)
- S. B. 820. An act concerning narcotics, providing for amending Sections of the uniform narcotic drug act of Connecticut. (P.H.S.)
- S. B. 803. An act concerning public health. (Senator Bingham.) Providing that hospitals or other institutions receiving State grants and health institutions supervised by at least five licensed physicians may advise and prescribe for married persons regarding marriage problems and may give them protection and supplies conducive to health notwithstanding the provisions of Sections 6244, 6246 and 6562. (Birth control bill.) (P.H.S.)
- S. B. 824. (Senator Geelan.) An act concerning the practice of osteopathy. (Blank bill.) (P.H.S.)
- S. B. 828. An act concerning the costs of maintenance of persons confined in State institutions. (Blank bill.) (H.I.)
- S. B. 979. Personal income tax bill. (Blank bill.) (Finance.)
- S. B. 1032. An act concerning chiropractic. (Blank bill.) (Jud.)
- S. B. 1034. Amends Section 1596c to make husband and wife liable for hospital expenses. (Jud.)
- S. B. 1057. Requires a physical examination before appointment in the State employ. (Jud.)
- S. B. 1070. Provides a limit of \$5.00 on outside calls and \$1.50 on office visits by physicians. (Jud.)
- S. B. 1088. Providing compulsory automobile insurance. (Jud.)
- S. B. 1107. Amends Section 246 providing for authority to medical examiner as well as coroner to order autopsies after death by presumed criminal act or where there is uncertainty as to the cause or manner of death. (Jud.) (Introduced by the State Medical Society.)
- S. B. 1112. Places physicians, nurses and dentists in non-competitive service in State employ. (Jud.)
- S. B. 1145. Provides examination for venereal disease of convicted offenders in vice cases. (Jud.)
- S. B. 1153. Compulsory automobile liability insurance. (Jud.)
- S. B. 1159. An act concerning chiropractic. (Blank bill.) (Jud.)
- S. B. 1193. Provides that persons employed in the manufacture and bottling of beverages shall be required to file health certificates with the Dairy and Food Commissioner. (P.H.S.)
- S. B. 1197. Provides an appropriation to establish a medico-legal laboratory for toxicological and other necessary investigations. (Blank bill.) (Introduced by the State Medical Society.) (P.H.S.)
- S. B. 1202. Provides that a certificate for cremation be furnished by the State Department of Health instead of the Registrar of Vital Statistics. (P.H.S.)
- S. B. 1235. Abolishes the Dairy and Food Commissioner and transfers all of his powers and duties to the Department of Health. (S.A.)

HOUSE BILLS

- H. B. 18. Establishes a Statewide Central Social Service Index by the Public Welfare Council and appropriates \$12,800. (H.I.)
- H. B. 19. Increases minimum amount old age assistance to \$40.00 a month, payable semi-monthly. (Jud.)

- H. B. 25. Repeals Section 640e to 703c. Abolishes the Merit System for State employees. (Jud.)
- H. B. 26. Reduces automobile operators' licenses to \$.50 from \$3.00. (M.V.)
- H. B. 27. To safeguard the distribution and sale of certain dangerous, caustic or corrosive acids, alkalis and other substances. Provides penalty of fine or imprisonment. To be enforced by the State Health Department. (P.H.)
- H. B. 32. Provides for an appropriation of \$50,000 for the biennium for the maintenance of cancer clinics. (App.)
- H. B. 57. Provides for a constitutional amendment making a four year term of office for the governor, lieutenant-governor, treasurer, secretary, comptroller and attorney-general. (C.A.)
- H. B. 63. Amending the charter of the American School for the Deaf at Hartford by the addition of the Commissioner of Education, the Commissioner of Finance and Comptroller of the State of Connecticut to the board of directors. (Edu.)
- H. B. 65. Provides appointment of pupils to the schools for the deaf by the Commissioner of Education. (Edu.)
- H. B. 75. Converts the Mystic Oral School to an institution for care of persons requiring only custodial care and places its administration under the board of trustees of the Norwich State Hospital. (H.I.)
- H. B. 76. Provides that state aided general hospitals shall incur no loss for the care of state patients. (H.I.)
- H. B. 77. Creates a Council on Mental Health with a director of mental health to direct and coordinate activities of institutions for the mentally sick, epileptic and inebriate. (H.I.)
- H. B. 78. (S. B. 223 and 397.) Abolishes the Mystic Oral School for the Deaf. (H.I.)
- H. B. 79. Creates a commission to study the needs of the care of the chronically ill and make recommendations relating thereto. (H.I.)
- H. B. 82. Provides that the licensing of institutions for the care of the insane, now a function of the State Department of Health, be transferred to the Council on Mental Health that would be established under H. B. 77. (Jud.)
- H. B. 99. Concerning the admission of insane persons to hospitals on certificate, providing for admission of persons mentally disturbed by reason of use of drugs, alcohol or poisons on physicians' certificates. A new method for admission of patients to state hospitals for the insane. (Jud.)
- H. B. 103. Increases old age assistance awards to a maximum of \$10.00 and a minimum of \$8.00. (Jud.)
- H. B. 105. Provides for the revocation of motor vehicle operators' licenses of judgment debtors. (Jud.)
- H. B. 112. Provides that physicians and dentists employed in the state merit system shall be licensed to practice medicine and surgery or dentistry in the State of Connecticut or are eligible for such licenses. (Jud.)
- H. B. 123. Provides for a department of automobile accident relief consisting of a commissioner, five accident relief referees with offices in the five congressional districts. Establishes a State fund to provide medical and hospital care for persons injured in highway accidents when incapacitated for seven days or less the cost of which amounts to \$10 or more up to \$250 for actual expenses for medical, surgical and hospital and nursing expenses, \$1,000 death relief "to dependents," not to exceed \$250 for burial if there are no dependents. Permits care by and payment to "an authorized chiropractor." (M.V.)
- H. B. 126. Revises medical practice acts, requiring United States citizenship and certain other minor changes. Published in the Connecticut State Medical Journal, December 1940. (P.H.S.) (Introduced by the State Medical Society.)
- H. B. 127. Provides that the Commissioner of Health shall be required to have had graduate study and certificate in public health. (P.H.S.)
- H. B. 128. Amends Section 2635 by including the rehabilitation of the tuberculous in the functions of the Tuberculosis Commission. (P.H.S.)
- H. B. 184. An act concerning the practice of physiotherapy by technicians. Defines qualifications for the practice of physiotherapy and provides for a state board of examiners for physiotherapy technicians. (P.H.S.)
- H. B. 185. Concerning a serological blood test for syphilis in pregnant women. Prenatal Wassermann bill of the Public Health Committee of the State Medical Society. (P.H.S.)
- H. B. 241. An act concerning a State compensation insurance fund providing for a compulsory state workmen's compensation fund in the Labor De-

- partment, administered by a director and deputy; provisions for administration, custody, expenses, surplus and reserve, classification and rates, dividends, premiums, etc. (Jud.)
- H. B. 367. Concerning an appropriation to the Department of Health for the study of cancer and the maintenance of clinics. Appropriates \$50,000. (App.)
- H. B. 390. Amends Section 2405 as amended by Section 866e providing that in cities and boroughs of 40,000 or more the health officer shall hold a degree in public health or combination of training and experience approved by public health council and shall give all his time to the job. (C.B.)
- H. B. 392. A health commission in the Town of Milford. (C.B.)
- H. B. 476. Provides for the amending of Section 9 of Chapter 355 so as not to prohibit persons employed by the hospitals and sanatoria licensed by the State from assisting in the nursing and care of patients if adequate medical and nursing supervision is provided. (Jud.)
- H. B. 497. Concerning the defining of the practice of dentistry providing for acts declared to constitute said practice. (Jud.)
- H. B. 514. Concerning applications for licenses for the practice of dentistry. (Jud.)
- H. B. 530. Concerning hairdressers and cosmeticians, supervision by the State Department of Health. (P.H.S.)
- H. B. 531. An act amending an act concerning still-born children providing for including in such certificates such information as the State Department of Health may require. (P.H.S.)
- H. B. 539. Amends Section 938c concerning labeling of milk and cream providing for elimination in labelling of the day of the week when pasteurized and bottled. (Ag.)
- H. B. 541. Provides that imported milk and cream shall be produced on farm premises conforming to State sanitary conditions, providing for inspection of out-of-state farms, cost thereof to be paid by the importer. (Ag.)
- H. B. 566. Creating a Department of Social Welfare in the Town of Branford. (C.B.)
- H. B. 589. Reimbursing the Connecticut Homeopathic Medical Society in the sum of \$275 for legal services in securing a license for Dr. Benno Lipton. (Claims.)
- H. B. 591. Provides for reimbursing Edwin S. Hall in the sum of \$83.91 for legal fees for securing a license for Dr. Benno Lipton. (Claims.)
- H. B. 604. Concerning appointment of commissioners to Interstate Sanitation Commission. Provides for appointment by the Governor of a commission of five members three of which shall be the Commissioner of Health, the Commissioner of State Water Commission, and the Attorney General to coöperate with the Commissioner of the States of New York and New Jersey. Interstate Commissioners have power in regard to pollution of coastal and tidal waters within the signatory states. (F.R.)
- H. B. 605. Concerning appointment of authorities to enter into Interstate Sanitation Commission compacts. Companion to 604. (F.R.)
- H. B. 621. Concerning incorporating the family and children's center of Stamford for the purpose of helping families and individuals who have been disorganized by poverty. (Inc.)
- H. B. 640. An act amending Section 1596c Chapter 277, 1935 C. S. to G. S., making both husband and wife liable for the reasonable and necessary professional services rendered to members of the family. (Jud.)
- H. B. 647. Providing for aid to dependent children under 16 years of age under the supervision of the Commissioner of Welfare. (Jud.)
- H. B. 653. Concerning nursing. Providing for the qualifications of applicants for examination for industrial attendants. (Jud.)
- H. B. 662. Providing for the appointment by the court in civil or criminal proceedings of expert witnesses. (Jud.)
- H. B. 678. Providing for a test of alcohol in body fluids of motor vehicle operators in case of accidents. (Jud.)
- H. B. 702. Concerning the examination of drunken drivers by physician. Providing for a minimum examination fee of \$3.00. (Jud.)
- H. B. 732. Providing for the establishment of a fund for the purpose of disposing the expenses of hospitalization and physicians' fees in cases of injuries caused by motor vehicle accidents. (M.V.)
- H. B. 737. Concerning proof of financial responsibility by owners and operators of motor vehicles providing for the Commissioner of Motor Vehicles to suspend or revoke operators licenses

- until proof of financial responsibility is established. (M.V.)
- H. B. 768. (S. B. 125.) Revises Medical Practice Act. (Society bill.) (P.H.S.)
- H. B. 771. Provides that no one may sell any milk or cream unless pasteurized or from herds certified by the Commissioner of Domestic Animals as "safe natural milk." (Ag.)
- H. B. 773. Providing for appropriation of \$100,000 to the State Department of Health for the biennium ending June 30, 1943 for the control of cancer. (App.)
- H. B. 778. Providing for the appropriation to the State Department of Health of the sum of \$10,000 for arranging, indexing, permanent binding and preservation of original certificates of births, marriages and deaths received since July 1, 1906. (App.)
- H. B. 781. Appropriation for the Mt. Sinai Hospital increased from \$2,500 to \$10,000. (App.)
- H. B. 930. An act amending an act concerning the readmission of children in public schools on account of illness providing for an amendment of Section 263c of the 1935 Supplement by increasing the medical advisory powers in relation to the health of pupils attending public schools, who also in coöperation with the health officer shall interest teachers and nurses in the factors dealing with communicable disease control. (Edu.)
- H. B. 931. Amends 262c providing for the appointment of legally qualified practitioners as school medical advisors and two or more towns can unite in making said appointment and defining his duties. (Edu.)
- H. B. 932. An act concerning examinations by school medical advisors, providing for an amendment of 923 by providing that "each medical advisor shall make a prompt examination of all pupils referred to him by the school nurse, teacher, principal or superintendent" and shall supervise the sanitation of school cafeterias and food handlers. (Edu.)
- H. B. 933. Amends Section 925 by requiring a medical examination of pupils in the public schools once in three years and provides for the keeping of a record of such examination on forms prescribed by the State Board of Education. (Edu.)
- H. B. 990. An act concerning appropriations to hospitals, providing for no charge for State patients greater than \$8.00 per week except where approved by the Commissioner of Welfare. (H.I.)
- H. B. 1050. Provides it shall be unlawful for a person to enter a hospital or sanitarium to obtain a statement from a person therein unless such person shall agree five days before giving such statement. (Jud.)
- H. B. 1069. Provides for the striking out of the words "July 1, 1940" from Section 999e and inserting in lieu thereof the words "January 1, 1942." (Extension of time for waiver for trained attendants under the Nursing Practice Act.) (Jud.)
- H. B. 1115. An act concerning body fluid tests for operating under the influence of intoxicating liquor. Provides for subjecting the accused to such tests at the expense of the State. (Jud.)
- H. B. 1162. An act concerning the commitment of habitual drunkards and dipsomaniacs. Provides for their commitment when they are non-residents or when the state of residence is not known. (Jud.)
- H. B. 1203. Restores the Connecticut Eclectic Medical Examining Board, restores that board. (P.H.S.)
- H. B. 1204. Providing for requiring applicants for examinations for a certificate of registration for medicine and surgery to have a degree of Doctor of Medicine. (P.H.S.)
- H. B. 1205. Providing for transferring the Bureau of Occupational Diseases from the Department of Health to the Department of Labor, to be designated as Division of Industrial Health to investigate industrial establishments and work places with powers of supervision and correction. (P.H.S.)
- H. B. 1206. An act concerning the creation of a Bureau of Industrial Health in the State Department of Health. (Blank bill.) (P.H.S.)
- H. B. 1207. Provides for repealing 865c, provides for appointment of town health officers by the State Commissioner of Health. (P.H.S.)
- H. B. 1208. An act concerning reports of contagious diseases, provides for amending 975c to require use of the full name. (P.H.S.)
- H. B. 1369. Appropriates \$80,000 to defray the expenses of the Board of Mosquito Control. (App.)
- H. B. 1572. Provides for the appointment of an investigator for mental hospitals in Connecticut. (H.I.)

- H. B. 1573. Provides for the creation of a board to examine all mental patients prior to commitment to any private or State hospital. (H.I.)
- H. B. 1588. An act concerning hospital ambulances. (Blank bill.) (Jud.)
- H. B. 1612. Places physicians, nurses and dentists in the non-competitive classified service for State employment. (Jud.)
- H. B. 1644. Extends the period of parole for patients in State institutions from six months to one year. (Blank bill.) (Jud.)
- H. B. 1668. Amends Section 5139 to include municipal hospitals in the law covering liens on accident and liability insurance policies in favor of hospitals. (Jud.)
- H. B. 1688. Provides that the medical examiner shall notify the coroner if there is uncertainty as to the cause of death. (Jud.) (Introduced by the State Medical Society.)
- H. B. 1691. Provides that the coroner or medical examiner may cause an autopsy to be done if there is uncertainty of the manner of death. (Introduced by the State Medical Society. (Jud.)
- H. B. 1700. Provides that appointees as town health officers must be citizens of the United States. (Jud.)
- H. B. 1708. An act concerning chiropractic, to amend Section 2758. (Blank bill.) (Jud.)
- H. B. 1720. Authorizing courts of criminal jurisdiction to commit drug addicts to State prison for not more than five years. (Jud.)
- H. B. 1721. Concerns ambulance for State Police barracks. (Blank bill.) (Jud.)
- H. B. 1784. Creates an automobile insurance fund. (Blank bill.) (Jud.)
- H. B. 1806. Concerns motor vehicle financial responsibility. (M.V.)
- H. B. 1811. Provides for an increase in motor vehicle fees the excess of fees to be placed in a fund to pay claims for deaths caused by motor vehicles. (M.V.)
- H. B. 1813. Provides that hospitals or other health institutions receiving State grants and other health institutions under the supervision of practicing physicians may transmit information or prescribe contraceptive devices to meet health problems of married women. (Birth control bill.) (P.H.S.)
- H. B. 1814. Amends Section 262 to allow the medical examiner to order chemical or microscopic

examination of dead bodies. (Introduced by the State Medical Society.) (P.H.S.)

- H. B. 1815. Makes an appropriation to establish a laboratory for medico-legal toxicological and other necessary investigation. (Blank bill.) (Introduced by the State Medical Society.) (P.H.S.)
- H. B. 1816. Provides for semi-annual physical examinations for State employees who, during the performance of their duties, come in contact with persons afflicted with any infectious or contagious diseases. (P.H.S.)
- H. B. 1817. Provides that certificates permitting children to return to school after sickness may be executed by any duly qualified and practicing physician. (P.H.S.)
- H. B. 1847. Provides that certificate of cremation be given by the coroner or medical examiner of the town where death occurred instead of the health officer. (Introduced by the State Medical Society.) (P.H.S.)

Committees of the General Assembly

SENATE

Appropriations. Chairman, Joseph B. Downes, County Court House, Norwich; Pierre J. Laramée, 147 Valley St., Willimantic; Samuel H. Malkan, 380 Oak St., New Haven; Edward P. Egan, 939 Baldwin St., Waterbury; George L. Warncke, Wilton.

Judiciary. Chairman, Albert L. Coles, 271 Vine St., Bridgeport; Joseph P. Cooney, 355 Fairfield Ave., Hartford; Joseph Rourke, 65 Spring St., New Haven; Frank A. Murphy, 122 W. Morningside St., Hartford; William J. Shea, Manchester.

Public Health and Safety. Chairman, Edward P. Egan, 939 Baldwin St., Waterbury; Thomas F. Curtin, 30 Mason St., Torrington; Alfred Bingham, Salem; Herbert E. Baldwin, Bayberry Lane, Westport.

Public Welfare and Humane Institutions. Chairman, Theodore Brysh, 318 Broad St., Meriden; Joseph Rourke, 65 Spring St., New Haven; Joseph A. St. Germain, 464 Montauk Ave., New London; John A. Holbrook, Westbrook.

HOUSE

Appropriations. Chairman, Carl M. Sharpe, Abington; John Christensen, 88 Wilson Ave., Wilton; Irving J. Avery, 296 Wolcott Hill Rd., Wethersfield; Mrs. Nellie D. Stewart, Hoyt St., New Canaan; Frank L. Barlow, Stonington; William

M. Curtis, New Milford; Warren A. Field, Milford Point Rd., Milford; Mrs. Julia A. Keeney, Somersville; Charles P. Harper, Middlebury; Arthur G. Morse, East Woodstock; Thomas O'Connor, Darien; Clarence F. Andrews, North Haven; William R. Peterson, Bartlett St., Portland; Daniel J. Mahaney, 1309 Bank St., Waterbury; Joseph J. Gillotti, 49 Lincoln Ave., Danbury.

Judiciary. Chairman, William L. Hadden, 2 Treadwell St., West Haven; E. Lea Marsh, Jr., Old Lyme; Stanley P. Mead, Mead St., New Canaan; Harold E. Mitchell, Cedar Ledge Rd., West Hartford; Elbert G. Manchester, 51 Hinsdale Ave., Winsted; Milo A. Mitchell, Maher Bldg., Greenwich; Francis J. Fahey, Thompsonville; Milton M. Koskoff, 88 Trumbull Ave., Plainville; Herbert B. Wanderer, c/o Wilson, Hanna & Wanderer, Danbury; Charles S. House, 18 Scarborough Rd., Manchester; Charles W. Jewett, R. F. D. No. 2, Old Lyme; T. Emmet Clarie, Danielson; Abraham A. Ribicoff, 16 Sharon St., Hartford; Joseph P. O'Connell, 133 Main St., Bristol; Fred D. Faulkner, 262 Crescent St., New Haven.

Public Health and Safety. Chairman, Miss Finette B. Nichols, Fairfield; Allen F. Behnke, Glastonbury; C. William Janson, Westport; Ernest C. Carpenter, 33 Elm St., East Haven; John P. Whitehead, Pleasant Valley; Miss Florence J. Rockwood, North Franklin; Frank J. Francis, Main St., Durham; Miss Julia B. Mead, 10 Lenox Drive, Greenwich; Miner P. Rogers, West Cornwall; William B. Bradley, Sr., Beacon Falls; Warren L. Hunt, Bethlehem; J. Ward Porter, Star Route, Willimantic; Fred A. Munyan, Thompson; Ellsworth M. Bitgood, 60 Silver St., Middletown; Raymond McMullen, Moodus.

Public Welfare and Humane Institutions. Chairman, John E. Lamb, 67 Broad St., Plainville; Mrs. Florence A. Abercrombie, 85 Warwick Ave., Stratford; Lyman E. Hall, Kensington; Mrs. Belle D. Russell, Haddam; Chauncey E. Hutchings, R. D. No. 2, Torrington; Frank L. Barlow, Stonington; William H. Coon, R. F. D. No. 1, Bridgeport; Mrs. Maud L. Woodward, R. F. D., Manchester; Henry T. Johnson, North Woodstock; Miss Eleanor H. Little, Guilford; Philip E. Curtiss, Norfolk; Verson

M. Boothby, Chestnut Hill; Bertha G. Hesper, R. F. D., Deep River.

A New Journal, "Cancer Research"

The first number of the new journal, *Cancer Research*, (to be issued before the middle of February) contains 13 original articles and 241 abstracts of papers published in the latter half of 1940. Designed primarily as a monthly journal of articles and abstracts reporting results of research on cancer the new publication plans to make information available to laboratory workers, clinicians, and all persons concerned with the attack on malignant disease.

The need for this new journal has arisen because other journals in the field are being prevented by the war and other conditions from meeting the needs of prompt publication of an increasing volume of reports of cancer research. During the past twenty years there has been a great development of interest in the cancer problem as shown by the number of workers attracted to the field and by the increased financial support which has become available for the work. The resultant larger volume of reports of fundamental investigations has emphasized the need for improved facilities for prompt and economical publication. The increase in number of workers and the increase in number of institutions and laboratories engaged in cancer research also increases the need for pooling information in order to advance essential coöperation in the attack on the problem. In response to these needs three Foundations, The International Cancer Research Foundation, The Anna Fuller Fund, and The Jane Coffin Childs Memorial Fund for Medical Research have entered into coöperation with the American Association for Cancer Research in launching this new journal.

The management of the journal is planned to be as economical as possible, based on the experience of another successful scientific journal. The subscription price to members of the Association is \$5.00; for those who are not members and for institutions and libraries the subscription rate is \$7.00. The business office is at 1620 Lincoln-Liberty Building, Philadelphia. The editorial office is at 333 Cedar St., New Haven, Connecticut.

NEW SERVICE — The Professional Equipment Company of New Haven reports that requests from the lay public for short wave equipment for home use have consistently been refused by them without a doctor's prescription, but the increasing demand suggests that some doctors may be overlooking this service to patients. No inquiry will be handled without a doctor's sanction, but, with medical guidance, short wave rental machines are available for the patient's use at home.

NEWS

from County Associations

Fairfield

Doctor Oliver L. Stringfield of Stamford, member of the Editorial Board of the JOURNAL, addressed the Essex County (N. J.) Medical Society recently on "Factors Affecting Mortality Rates Among Premature Infants."

The Y. M. C. A. of Bridgeport held its annual Health Week from February 16 to 23. Because of the increase in industrial activity, largely a part of the defense program, the text for this year's Health Week was "Industrial Medical Hazards." About fifty lectures or movies were given before Industrial, Church, or Luncheon club groups. Coöperating with the Y. M. C. A. were members of the city health department, dentists and physicians.

Over 60 members of the Stamford Medical Society attended the annual January dinner of the society, held at the Hubbard Heights Golf Club. The election of officers resulted in the following slate for 1941:

President: Eugene F. Meschter.
First Vice-President: Russell A. Keddy.
Second Vice-President: Frederick M. Bannon.
Secretary: Paul Brown.
Treasurer: Leo Hymovich.

Clarence H. Beecher, Professor of Medicine at the University of Vermont School of Medicine, addressed the Stamford Medical Society at the auditorium of the Stamford Hospital on February 11. A capacity audience heard Doctor Beecher give a very common sense discussion of disorders of the heart in a paper entitled, "Arteriosclerotic and Hypersensitive Diseases of the Heart."

Stamford physicians are continuing their interest in civic affairs. At the last local election, Doctor E. Everett Rowell, city councilman, and Doctor David P. McGourty, member of the Board of Finance, were both returned to office. Doctors Edward F. Malloy and Jay E. Starrett were elected president and vice-president, respectively, of the Stamford Lions Club.

Doctor James E. Crane of Stamford, a Lieutenant

in the Army Reserve Corps, reported for active duty at Fort Benning, Georgia, on February 14.

Hartford

Doctor Richard A. Outerson's death recently is a source of great loss and mourning to his legion of friends and his clientele. Among the most affable of individuals, possessed of good judgment and always ready to be of help, he had become the confidant of many doctors who now miss him keenly. After hours his office was a friendly meeting place where fellow physicians came to chat and converse on any and all topics. Many as individuals with discouraging and annoying medical or surgical problems came to him for solace, sympathy and oftentimes great aid. He will long be remembered.

On February 3 the Hartford Medical Society had the honor and pleasure of having Doctor Reginald Smithwick of Boston and the Massachusetts General Hospital staff give a discourse on work in reduction of hypertension by sympathectomy. In the afternoon at 5:00 P.M. he gave an interesting clinic at the Hartford Hospital.

New Haven

Doctor Clifford Kuh of New Haven, Chairman of the Committee on Industrial Health, Connecticut State Medical Society, is the author of an article entitled, "Industrial Health, An Old Year Concept With a New Year Meaning," which appeared in *Connecticut Industry* for January, 1941. Doctor Kuh presented this before the New Haven Rotary Club at a recent luncheon.

New London

The New London City Medical Society held its annual meeting and banquet, January 17, at the Mohican Hotel. The following officers were elected for the ensuing year:

President—Anthony Loiacono.
Vice-President—Charles Dyer.
Secretary-Treasurer—Joyce Morris.
Librarian—Hill F. Warren.

Executive Committee—Thomas J. Murray, Alfred Labensky and Robert T. Henkle.

Doctor Morris Sulman, 199 Montauk Ave., New London, Lieut., M.C., (R), U.S.A., was ordered to active duty to report at New Haven State Armory, February 24, for a period of duty of fourteen (14)

days for the purpose of conducting physical examinations upon the induction of the 43rd division National Guard into the Federal service.

Doctor Leslie VanRaalte, interne at the Lawrence Memorial Hospital, New London, 1937, has recently completed his residency in Obstetrics and Gynecology at Boston City Hospital. He is at present engaged in the practice of that specialty in Quincy, Mass.

Two thousand (2,000) patients were x-rayed in the tuberculosis campaign conducted by the local health department February 3, 4, and 5, at the old Hook & Ladder Fire House. Seven hundred (700) patients were in the 15 to 45 age group. In about three weeks reports will be mailed to the family physicians of all patients. The local health authorities are elated by the large attendance of patients and are most grateful for the splendid coöperation obtained from the local medical profession, industrialists and the medical staff of the local tuberculosis hospitals, Uncas-on-the-Thames and Seaside.

The New London County Medical Association held its monthly scientific meeting at Uncas-on-the-Thames, Norwich, February 6. The subject of the evening was: "Acute Abdominal Pain in Children." The speakers were: Drs. R. C. Eley and Patrick J. Mahoney, Children's Hospital, Boston. Doctor Eley spoke on the medical aspect of the subject, Doctor Mahoney took care of the surgical side. The papers were very well received by a large attendance.

Following the talks by Drs. Eley and Mahoney, Doctor Daniel Sullivan and Doctor Robert T. Henkle of New London spoke on Medical Preparedness. Doctor Sullivan is County Chairman of the State Medical Society Medical Preparedness Committee. Doctor Henkle represented the local Red Cross Chapter.

Doctor Mario Albamonti of Westerly, R. I., who completed his internship at the William Backus Hospital, Norwich, last month, has opened an office for the general practice of medicine in the Young Building, Main Street, Norwich.

News from Yale University School of Medicine

Doctor Francis G. Blake, Acting Dean of the Medical School, has been appointed President of a Board for the Investigation and Control of Influenza and other epidemic diseases in the United States Army. Other members of the Board are Doctors A. R. Dochez of New York City, O. H. Perry Pepper of Philadelphia, and E. W. Goodpasture of Nashville, Tenn. The Board was appointed by the Secretary of War on recommendation of Surgeon General Magee.

Associate Professor George R. Cowgill has been made a member of the Scientific Food Committee which is to study scientific aspects of nutrition in relation to the defense program under the authority of the National Research Council.

A monumental text and reference book on pharmacology, entitled "The Pharmacological Basis of Therapeutics," has just been released by Macmillan Company. The authors, Doctors Louis Goodman and Alfred Gilman, are assistant professors in Department of Pharmacology.

Doctor Joseph Sadusk, Instructor in Medicine, addressed the New Haven County Medical Association on February 5. His subject was "General Aspects of Chemotherapy."

Doctor Alexander Winkler, reporting a research done with the collaboration of Doctors Hebel Hoff and P. K. Smith, spoke on "The Cause of Death in Experimental Anuria," before the Yale Medical Society on February 12.

Doctor Paul Laviertes, Assistant Professor in Medicine, addressed the staff of Grace Hospital on January 12. His subject was "The Treatment of Diabetes."

LISTEN TO A FOETAL HEARTBEAT — through the new "two-channel" Davol Stethoscope Tube. This modern tube will improve your present stethoscope. Latex for long life, heavy wall for durability and to exclude extraneous sounds, with length and weight just right to make it easy to carry and easy to use. One tube; twin channels. No obligation—want to try one? Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

OBITUARIES

George William May, M.D. 1860 - 1940

George William May was born in Carlisle, Northumberland, England April 11, 1860 where he received his early education. In 1882, at the age of 22, he came to Manchester, Conn., and later the same year he went to Philadelphia, Pa. Three years later he returned to Manchester and took a clerical position with Cheney Brothers Co., and remained with them until he entered the Maryland Medical College in Baltimore in 1891.

After two years in Maryland Medical College, he transferred to the Milwaukee College of Wisconsin, graduating in 1895. He was one of the first two men to pass the Connecticut State Medical Examining Board at New Haven in June of that year.

He located in Willimantic, Conn., doing general practice and in 1898 and '99 he spent a year in the New York Eye and Ear Infirmary. Following this he specialized in eye, ear and throat diseases in Willimantic and Manchester. In 1920 and '21 he spent a year in London under the then newly organized Fellowship of Medicine, studying at the London Ophthalmic Hospital. He was appointed assistant to the Chief of Clinic in the nose and throat department at Prince of Wales Hospital, London, England, being the first American citizen to be appointed to such a position. Returning in 1921 to Manchester he practiced his specialty until his death. Dr. May was a great reader and a student of his profession and of history. Although past the age limit, at the time of the last World War he offered his services to the Government and examined 1200 men in the draft from the Manchester area.

He is survived by his wife, Isabelle Mitchell May. He was deeply devoted to his mother country, England, and to his adopted country, the United States, and was greatly concerned with their fortunes, watching the present day war news up to the very last.

In the death of Doctor May the medical profession has lost a staunch friend and a supporter of the fundamental principles and traditions that have been such factors in making of medicine what it is today.

D. C. Y. Moore, M.D.

J. Tyree Woodson 1893 - 1940

Doctor Jacob Tyree Woodson was born in Gallatin, Tennessee, in the year of 1893. His preparatory education was attained at the Hawkins School in Gallatin, and his Bachelor of Arts degree from Vanderbilt University in 1915. His scholastic record was an enviable one and in his Junior year in Vanderbilt he was elected to the Phi Beta Kappa honorary society. For one year after graduation he taught English at the Hawkins School, his Alma Mater. In 1920 he was graduated from Columbia College of Physicians and Surgeons, coming to the Hartford Hospital as an interne a few months thereafter. During his student days he enlisted in the Naval Reserve and was honorably discharged in 1921. After completing his internship in 1922 he entered the practice of medicine in Hartford. For several years he was a member of the Medical Staff of the Aetna Life Insurance Company. He was assistant secretary of the Hartford Medical Society in 1935 and Secretary for the year 1936. He was a member of the Staff of the Hartford Hospital and of the Municipal Hospital, the Hartford County Medical Association, the Connecticut Medical Society, and a Fellow of The American Medical Association.

Doctor Woodson was possessed of a brilliant mind and a loyalty to duty which at times was a severe tax on his physical strength. In his care of patients he was more than generous, especially to the poor, in giving of his time and energy. A thoroughgoing honesty and love of the truth were among his outstanding characteristics.

At the age of fifteen he suffered an attack of rheumatic fever which left him with an impaired heart. During the last several years of his life this became an increasing handicap and finally was responsible for his death on November 9, 1940.

In November, 1929 he married Lucy Hodges Woodson, who survives him with three sons, Thomas M., John H., James Lee; his mother, Mrs. John Woodson of Nashville, Tennessee; a sister and two brothers.

James E. Davis, M.D.

SPECIAL NOTICES

MEETING OF ASSOCIATION OF CONNECTICUT TUMOR CLINICS, GRACE HOSPITAL, NEW HAVEN, THURSDAY, MARCH 6th

4:00 P. M.

General Considerations regarding the Cancer Problem in
Metropolitan New Haven. Dr. William Mendelsohn

Cancer of the Stomach in Metropolitan New Haven.

Dr. Ralph W. Nichols

Cancer of the Stomach in Grace Hospital.

Dr. Samuel Spinner

The Role of Radiology in Cancer of the Stomach.

Dr. William G. H. Dobbs

NEW HAVEN ON THE AIR

The New Haven Medical Association

RADIO BROADCAST SERIES—1941—STATION WICC "EDUCATION IN HEALTH"

The New Haven Medical Association, in coöperation with the New Haven Department of Health and the Council of Social Agencies, is presenting a series of health talks for public education under the title of "Education in Health." These broadcasts are being given over Station WICC every Thursday afternoon at 2:30 o'clock as follows:

February 6 The Prevention and Cure of Diabetes

Dr. B. Greenhouse

13 Nasal Catarrh Dr. H. L. Berman

20 Where to Get your Vitamins Dr. G. R. Cowgill

27 Treat Your Hay Fever and Prevent Asthma

Dr. B. Freedman

March 6 Who Is Your Doctor? Dr. C. Barker

13 Common Ways of Meeting Mental Difficulties

Dr. L. Shapiro

20 So You're Going to Have a Baby!

Dr. A. N. Creadick

27 Soldier's Heart Dr. H. Arnold

April 3 Sulfanilamide—The Wonder Drug

Dr. J. F. Sadusk, Jr.

10 Cancer of the Skin Dr. E. A. Abbey

17 Hysteria in Surgery Dr. P. W. Vestal

24 The Role of the Public at the Scene of an Accident

Drs. E. F. FitzSimons, D. Poverman and A. L. Shure

May 1 Pediatric Superstitions Drs. T. E. Shaffer,

W. R. Wilson and P. F. McAlenney

8 Pioneers in Medicine Dr. J. F. Fulton

15 Swollen Hands Drs. C. C. Bishop,

M. Taffell and J. C. Mendillo

22 Care of the Feet in Elderly People

Dr. K. W. Thompson

29 Frontiers in Medicine Dr. L. H. Nahum

The June program will be conducted by the Nutrition Committee, Community Chest and Council of Social Agencies.

AMERICAN ACADEMY OF PEDIATRICS

Meeting of Region 1

New Haven, Conn.

March 27, 28, 29, 1941

Headquarters, Hotel Taft

PROGRAM

Thursday, March 27, 1941

Registration, Hotel Taft, 2 to 8 P. M.

8 P. M. Smoker, Room 117

*Presiding, OLIVER L. STRINGFIELD, M.D., Stamford
Connecticut Chairman, American Academy of Pediatrics*

Problems of Pediatric Practice

LEWIS WEBB HILL, M.D.

CLIFFORD G. GRULEE, M.D.

STANLEY H. NICHOLS, M.D.

RICHARD M. SMITH, M.D.

Auditorium, Sterling Law Buildings, Yale University

Friday Morning, March 28, 1941

HEMOLYTIC STREPTOCOCCAL DISEASE IN CHILDREN; RHEUMATIC FEVER

Presiding, JOSEPH I. LINDE, M.D.

Clinical Professor of Pediatrics and Public Health,
Yale University School of Medicine;

Health Officer, City of New Haven, Connecticut

10:00 Streptococcal infections

GROVER F. POWERS, M.D., Professor of Pediatrics,
Yale University School of Medicine

10:20 Diagnostic procedures in streptococcal infections

PAUL L. BOISVERT, M.D., Instructor in Pediatrics,
Yale University School of Medicine

10:40 Treatment of streptococcal infections

A. CLEMENT SILVERMAN, M.D., Professor of Clinical
Pediatrics, Syracuse Medical School

Intermission

11:10 Incidence of rheumatic fever

O. F. HEDLEY, M.D., Surgeon, U. S. Public Health
Service, National Institute of Health, Bethesda,
Maryland

11:30 Observations on the effect of streptococcal upper
respiratory infections on rheumatic children: A three
year study

ANN G. KUTTNER, M.D., Medical Director of Ir-
vington House, Irvington on Hudson, New York

11:50 Rheumatic fever in relation to the family and environ-
ment

JOHN R. PAUL, M.D., Professor of Preventive
Medicine, Yale University School of Medicine

Friday Afternoon, March 28, 1941

ORTHOPEDIC CONDITIONS OF PRIMARY INTEREST TO THE PEDIATRICIAN

Presiding, J. HAROLD ROOT, M.D.
Waterbury

- 2:00 The detection of virus in field studies by the Yale
Poliomyelitis Commission
JAMES D. TRASK, M.D., Associate Professor of
Pediatrics, Yale University School of Medicine
- 2:20 The use of physical therapy in pediatric cases
MURIEL CASE DOWNER, M.D., Instructor of Physical
Therapy, Yale University School of Medicine
- 2:40 A community program for the care of crippled chil-
dren in New York City
VERNON W. LIPPARD, M.D., Assistant Dean of the
College of Physicians and Surgeons, Columbia
University, New York City

Intermission

- 3:10 Treatment of certain congenital deformities in chil-
dren
ALEXANDER L. BASSIN, M.D., Assistant Professor of
Orthopedic Surgery, Yale University, School of
Medicine
- 3:30 Birth injuries
WINTHROP M. PHELPS, M.D., Baltimore
- 3:50 Osteochondritis juvenalis—all forms
M. BECKETT HOWORTH, M.D., New York City
- 5:00 Beaumont Lecture
RICHARD H. SHRYOCK, History Department, Uni-
versity of Pennsylvania
- 7:00 Banquet, Ball Room, Hotel Taft
Toastmaster—ERNEST CAULFIELD, M.D., Hartford
Speaker—HON. ODELL SHEPARD, PH.D., LITT.D., Lieu-
tenant-Governor of the State of Connecticut,
James J. Goodwin Professor of English Literature,
Trinity College, Hartford. Poet, Essayist, Bio-
grapher and Pulitzer Prize Winner. His subject
will be: "Unicorn's Horn as Materia Medica."

Saturday Morning, March 29, 1941

CERTAIN PROBLEMS OF PUBERTY AND ADOLESCENCE

Presiding, HOWARD W. BRAYTON, M.D.
Hartford

- 10:00 General considerations
LAWRENCE K. FRANK, Vice-President, Josiah Macy,
Jr. Foundation, New York City
- 10:20 Some observations on the growth and development
of adolescent children
WILLIAM W. GREULICH, PH.D., Professor of Phys-
ical Anthropology and Anatomy, and Director
of the Brush Foundation, Western Reserve Uni-
versity
- 10:40 Obesity in relation to puberty
HILDE BRUCH, M.D., Instructor in the Department
of Pediatrics, College of Physicians and Surgeons,
Columbia University, New York City

Intermission

- 11:10 Gynecological problems of adolescence
ARTHUR H. MORSE, M.D., Professor of Obstetrics
and Gynecology, Yale University School of Medi-
cine
- 11:30 Endocrine therapy
EPHRAIM SHORR, M.D., Assistant Professor of Medi-
cine, Cornell University Medical College
- 11:50 Psychiatric considerations
DOUGLAS A. THOM, M.D., Director of the Habit
Clinic for Child Guidance, Boston, Mass.

Saturday Afternoon

Visit to Clinic of Child Development, Institute of Human
Relations,

Dr. Arnold Gesell, M.D., Director

Visit to Southbury Training School: Ernest N. Roselle,
Superintendent; Dr. Herman Yannet, M.D., Director of Med-
ical and Health Services

COMING MEETINGS

Annual Meeting, Connecticut State Medical Society, Strat-
field Hotel, Bridgeport, May 21-22.

Association of Connecticut Tumor Clinics, Grace Hos-
pital, New Haven, March 6, 4:00 P. M.

American Academy of Pediatrics, Region 1, New Haven,
March 27-29.

American Medical Association, Cleveland, June 2-6.

American College of Physicians, Boston, April 21-25.

American Association of Anatomists, Chicago, April 9-11.

American Association of Pathologists and Bacteriologists,
New York, April 10-11.

American College of Physical Therapy, Washington, D. C.,
September 1-5.

American Gastro-Enterological Association, Atlantic City,
May 5-6.

American Roentgen Ray Society, Cincinnati, Oct. 6-11.

American Society for Clinical Investigation, Atlantic City,
May 5.

American Urological Association, Colorado Springs, May
19-22.

NEW ENGLAND HEALTH INSTITUTE

"Public Health in National Defense is the theme of the
11th New England Health Institute which will be held at
the Hotel Statler, Boston, April 2, 3, and 4. Speakers of
national prominence will be in charge of many of the ses-
sions. Doctor Thomas Parran, Surgeon General of the
United States, is to speak at the general meeting on Wednes-
day evening. Brigadier General Frederick F. Russell of the
Medical Reserve Corps will be the speaker at a dinner on
Thursday evening. Connecticut will be represented in the
list of speakers by Doctor Osborn, Professor Hiscock, Doc-
tor Haggard, Miss Douglas, Doctor Robert M. Lewis, and
several from the State Department of Health.

QUARTO NOTES

METHODS OF TREATMENT. (7th edition.) By Logan Clendening, M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas; Attending Physician, University of Kansas Hospitals and Edward H. Hasbinger, A.B., M.D., Clinical Professor of Medicine, Medical Department University of Kansas; Attending Physician, University of Kansas Hospitals; Attending Physician, St. Luke's Hospital, Kansas City, Mo. There are chapters on special subjects: Anesthesia by Paul H. Lorhan, M.D.; Infant Feeding by Joseph B. Cowherd, M.D.; Physical Therapy by Roland F. Glaser, M.D., and Carl O. Rickter, M.D.; Radiotherapy by E. H. Skinner, M.D.; Treatment of Diseases due to Allergy by Orval R. Withers, M.D.; Special Descriptions and Treatment of Artificial Pneumothorax by Lawrence E. Wood, M.D.; The Treatment of Infantile Rickets and Infantile Scurvy by Frank C. Neff and Diseases of the Esophagus by John S. Knight, M.D. St. Louis: C. V. Mosby Company. 1941. 997 pp. 138 illustrations. \$10.00.

Reviewed by C. L. THENEBE

The statement that a book is outdated before it is off the press is true, especially wherein new methods of treatment are undergoing rapid and radical changes.

Methods of Treatment covers such a wide scope that it is not to be wondered that there are found many strong but also a few weak chapters. Pertaining to those sections which are lacking, a few justifiable criticisms can be made. For instance, under Infectious Diseases, we find under the treatment of infantile paralysis—"Convalescent serum is the only effective therapy at present available. It is administered intraspinally." According to popular opinion this treatment is definitely contraindicated because it produces an aseptic meningitis and may even increase any existing edema of the involved ganglion cells, thereby accelerating the development of paralysis. It even may be fatal to the case presenting bulbar involvement. Additional paragraphs pertaining to scattered sections in the book should be made more informative or be deleted entirely. As has already been mentioned, the weaknesses are compensated by the abundance of valuable instructive matter found in the various chapters on drugs, anesthesia, immunologic products, extracts of ductless glands, allergy, dietetics, physical therapy, radiotherapy, climate, psychotherapy and the treatment of the diseases of the various special body or bodily systems. Many medical procedures are described in adequate detail. Many illustrations are of aid in mastering some of the special techniques of treatment. However, plates of normal and abnormal blood cells, normal and abnormal urinary findings, normal and abnormal blood findings and normal and abnormal cardiographic tracings are absent and might well be added to the next edition.

Methods of Treatment is a valuable text book well worthy

of the attention of all internists, general practitioners, internes and specialists who desire to familiarize themselves with the therapeutic management of morbid conditions other than in their own field.

HUGH YOUNG: A SURGEON'S AUTOBIOGRAPHY. New York: Harcourt Brace & Co. 1940. 554 pp. 100 drawings. \$5.00.

Reviewed by CHARLES Y. BIDGOOD

Thanks dear God for the many favors vouchsafed me during my first seventy years. May the second seventy be more fruitful.

The verve which prompted Dr. Young to write these lines on his 70th birthday is one of the most important forces in the life of a man who has lived seventy years, all of which have one common characteristic—action. It is the same spirit which dared him to drink his father's toddy at the age of eighteen months, and write his autobiography while in a sick bed. Between these two events this book records a life of enthusiasm for living, and of successful accomplishment of any work he attempted.

In this story Dr. Young does not portray the philosopher in so far as the broad aspect of human behavior is concerned, but rather the brilliant thinker and tireless worker on the practical problems he faced. It made no difference whether the task was surgical, military, political or refurbishing the Baltimore Club. He lent his tremendous energy to it without stint until the operation was a success, the military objective achieved, and the politicians bearded at their banquet, or the proper tapestries and portraits obtained for the club.

This book reveals Dr. Young's life, at least the first seventy years of it, to have been spent in rather well defined phases, after his arrival at the Johns Hopkins Hospital and inaugurated what was to be his life's work.

First—The surgeon, recognizing pathological conditions hitherto unnoticed, devising operations for their correction and inventing instruments to make the performance of them practical. In these endeavors no organ of the urogenital tract failed to benefit by his surgical ingenuity.

Second—the soldier. Dr. Young has always been proud of the martial record of his family, and so when war was declared in 1917 he went to France on General Pershing's ship as chief urological consultant to the A.E.F. The story of the next few years in France is told with gusto. It roves through all war torn France and even embraces the bordellos of Saint Nazaire. Beside these, there was written the Manual of Military Urology, and a description of a trip to Belgium and the Rhineland after the Armistice. This was an active and interesting period and the story is told without reticence. The only note of regret is that in his hurried exit from the scene he was unable to say goodbye to the princess who had been so kind to him.

Third—the citizen. Dr. Young's political and civic activities have been so numerous and varied that it is amazing how, with his surgical cases, he found time to accomplish them. He describes his vote in the management of tuberculosis and insanity by the state, and the bringing of grand opera to Baltimore. Also, a number of other isolated in-

stances in which he was called upon and which he brought to a successful conclusion for the benefit of Maryland, Baltimore, and the Johns Hopkins Hospital.

Throughout all of these cycles there is depicted the builder and the author. He tells of the building of a surgical clinic, a club, museums, and even a bridge. This book is eloquent testimony of not only his ability but his versatility. As an author, this is his first non-professional book and it is written with a delightful and charming grace.

Above all else it reveals the man. One who has lived exuberantly, who has been indefatigable in transforming his conceptions into deeds, and who would never:

"Let enterprizes of great pitch and moment
with this regard their currents turn awry
and lose the name of action."

Hamlet: Act 3, Sc. 1.

CLINICAL PELLAGRA. By Seale Harris, Professor Emeritus of Medicine, University of Alabama. St. Louis: C. V. Mosby Company. 1941. 494 pp. 66 illustrations. \$7.00.

Reviewed by M. J. STRAUSS

Approximately the first one third of the text of this monograph is devoted to a repetitive detailing of the history of pellagra. The author discusses in turn the history of pellagra in Europe and in the United States, then alcoholic pellagra, the etiology, the toxin theories, the relation of infections, the food deficiency theories, animal experimentation and vitamin deficiency theories. In each of these chapters he goes back to the beginning, thus necessarily repeating much material. In reading this section of the book one is continually conscious, as one is conscious of an underlying theme in a musical composition, of the author's preoccupation with a very definite idea. He admits that the so-called pellagra-preventive factor or nicotinic acid can be used successfully to cure pellagra, but he feels strongly that there is something else behind the scenes which causes this specific deficiency to exist in some people and not in others. He postulates the existence of either endotoxins or exotoxins. The former, he believes may be present because of pathologic conditions of the stomach or liver or both. As far as the exotoxins are concerned, Dr. Harris does not seem to have abandoned completely the old theory of a toxin in maize and he states very definitely that ethyl alcohol is a toxin. The logic of the author's reasoning is not always clear but he does bring out the idea that a deficiency of nicotinic acid is not the whole story of pellagra.

It is in the latter two thirds of the book that the real value lies. Ruffin and Smith have contributed an excellent chapter concerning the studies on pellagra at Duke University, Sydenstricker one on similar studies at the University of Georgia. Katherine Dodd discusses pellagra in children in a separate chapter and there is also a chapter on the heart in endemic pellagra by Porter and Higginbotham.

To this portion of the book Dr. Harris has contributed much concerning the symptomatology, diagnosis, prognosis, prophylaxis and treatment of the disease. He is at his best in this portion of the book. Dr. Harris knows pellagra and more than that he knows pellagrins and from his vast

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph. Gon. & Ven. Dis.*, 23, 201 (March) 1939.

*Silver Picrate, is a definite crystalline compound of silver and picric acid. It is available in the form of crystals and soluble irrigation for the preparation of solutions, suppositories, water-soluble jelly, and powder for vaginal insufflation.

experience can contribute a great deal. The portion of the monograph which concerns itself with treatment is of particular value. Here the author gives many practical suggestions concerning the use of diets as a supplement to the pure vitamins giving actual diets in detail. He makes a strong argument against the indiscriminate use of expensive vitamin preparations where there is no need for them or where the purpose can be as well served by an adequate and proper diet.

There is a comprehensive bibliography.

THE MEDICAL REPORTS OF JOHN Y. BASSETT, M.D. THE ALABAMA STUDENT, WITH INTRODUCTION BY DANIEL ELKIN, M.D. Joseph B. Whitehead Professor of Surgery, Emory University. *Springfield, Ill.: Charles C. Thomas. 1941. 62 pp. \$1.50.*

Reviewed by STANLEY B. WELD

Those of our readers who have enjoyed Sir William Osler's "An Alabama Student and Other Biographical Essays" will find renewed pleasure in the contents of this volume. John Y. Bassett, M.D., was the Alabama Student

whose philosophical essays have fascinated so many readers. He lived during that period when the doctrine of the "unity of fevers" prospered and topography was believed to influence disease to a large extent.

The publishers have afforded us Bassett's "Report on the Topography, Climate and Diseases of Madison County, Ala.," and his "Report on the Climate and Diseases of Huntsville and Its Vicinity for the year 1850." Seated by one's fireside perusing the contents one comes across such bits of wisdom as this: ". . . the science of French expectancy, and the quackery of German Homeopathy, have alike failed: dying men will have pills and parsons". And again: "When such an one reenters the world, he is a physician: his vast labors have not only taught him how little he knows, but that he knows this little well. Conscientious of this virtue, he feels no necessity of trumpeting his professional acquirements abroad, but with becoming modesty and true dignity, which constitute genuine professional pride, he leaves this to the good sense of his fellow-citizens to discover".

"An Alabama Student" was Harvey Cushing's favorite gift book.

Table of Contents : April 1941

ORIGINAL PAPERS

THROMBOPHLEBITIS; WITH PARTICULAR REFERENCE TO TREATMENT	Howard Mahorner, M.D., New Orleans	243
CONNECTICUT MEDICAL BIBLIOGRAPHY	Walter R. Steiner, M.D., Hartford	248
ON THE NATURE AND TREATMENT OF EPILEPSY	Tracy J. Putnam, M.D., New York City	257
SYMPTOMS COMPELLING ATTENTION TO THE HEART	Louis H. Nahum, M.D., and Pasquale Piccolo, M.D., New Haven	261
CONSERVATIVE TREATMENT IN FRACTURES OF THE NECK OF THE HUMERUS (ABSTRACT)	John J. Moorhead, M.D., New York City	267
SURVEY OF THE ANESTHESIA SERVICE AT GRASSLANDS HOSPITAL 1938 TO 1940	Harold F. Bishop, M.D., Valhalla, N. Y.	270
THE CONNECTICUT PEDIATRIC CONSULTING SERVICE	Martha L. Clifford, M.D., Hartford	280

CASE REPORTS

CASE OF WANDERING SPLEEN WITH TORSION OF THE PEDICLE SIMULATING A PELVIC TUMOR	Louis Lahn, M.D., New York City	274
THE APPENDICITIS SYNDROME DUE TO ALLERGY	D. Leonard Lieberman, M.D., Chester	277
DERMATITIS CAUSED BY NYLON STOCKINGS	Edward Gipstein, M.D., New London	278
CANCER OF THE COLON IN TWINS	J. Coll, M.D., and H. Humphrey, M.D., Hartford	279

EDITORIAL

The Warren Prize Comes to Connecticut	285	Doctor Sigerist Prescribes	287
Trigeminal Neuralgia	286	Health Here and In Europe	287
S. B. 529	286	Watch the National Physicians Committee!	288

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	289	LETTERS TO THE EDITOR	305
CONNECTICUT HOSPITAL ASSOCIATION	291	NEWS FROM COUNTY ASSOCIATIONS	306
MEDICAL PREPAREDNESS SECTION	296	NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE	309
LEGISLATIVE SECTION	300	QUARTO NOTES (Book Reviews)	313
THE FORUM	304		

MISCELLANEOUS

PRELIMINARY PROGRAM FOR 149TH ANNUAL MEETING	282	SPECIAL NOTICES	310
OBITUARY: Charles Wardell Stiles, M.D.		OFFICERS AND COMMITTEE CHAIRMEN	
S. Bayne-Jones, M.D.	313	Connecticut State Medical Society	4
		Connecticut Hospital Association	4

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The CONNECTICUT STATE MEDICAL JOURNAL

VOL. V

APRIL, 1941

No. 4

THROMBOPHLEBITIS; WITH PARTICULAR REFERENCE TO TREATMENT

HOWARD MAHORNER, M.D., *New Orleans*

The Author. A.B., *Spring Hill College, Mobile, 1921.* M.D., *University of Pennsylvania, 1925.* M.S., *University of Minnesota, 1928.* Assistant Professor of Surgery, *Tulane University, 1937 to date*

SURGICAL LESIONS of the venous system are receiving more prominent attention. This is justly due because of the great frequency of venous lesions which usually are gratifyingly amenable to treatment. Usually mild, the lesions are occasionally very severe and extremely dangerous. Progress, not only in understanding the physiology of these conditions, but also in their treatment, has been notable in the last few years. The solution of very many important questions has not been made, but the marginal advances, nevertheless have been important. The diseases of the venous system of surgical significance are not numerous. Many diseases of the veins are secondary to some more important lesion and the importance of a primary venous lesion is sometimes superseded by the changes produced in organs through which they course. Primary lesions of the veins of surgical significance are included in the following: (a) Thrombophlebitis; (b) Effort Thrombosis; (c) Venous Hemangiomas; (d) Varicose Veins; (e) Arteriovenous communications.

Thrombophlebitis, generally considered a minor lesion, can under some circumstances be exceedingly dangerous, and some types of thrombophlebitis are attended by a high mortality. Its varieties are several; and their classification is dependent upon the location and upon the infectious or aseptic character of the thrombosis. Thrombosis of veins such as the mesenteric or cavernous sinus may so affect the clinical picture that the attention is of necessity largely concerned with damage to the organ involved. In these instances the complications and secondary changes supersede the primary pathology in importance. These complex clinical syndromes will not be discussed, but attention is directed to

thrombosis mainly in peripheral veins where the thrombosis and venous pathology is the major lesion for which therapy is indicated. In the peripheral veins the occurrence of thrombosis is generally associated with one of the following four conditions:

- (1) Previous operation.
- (2) Infectious thrombophlebitis.
- (3) Trauma.
- (4) Varicose veins.

The origin of postoperative thrombophlebitis is not entirely understood. Not bacteriogenic, it is possibly due to retardation of the flow of blood and other factors. Anaerobic or aerobic cultures of thrombosed veins removed at this time do not yield a positive growth of organisms. The lesion is sometimes silent initially manifesting itself by the dreaded pulmonary embolism. Usually mild to severe pain, moderate temperature rises and swelling direct attention to the leg. Objectively a superficial vein may be hard and tender, or the calf of the leg alone may be tender, or the entire leg may be swollen, with tenderness over the course of the femoral vein. Unexplained fever in the convalescent period should indicate among others the necessity of examining the extremities. Occasionally the fever and tenderness in the calf of the leg are the only findings indicating phlebitis.

Infectious thrombophlebitis may be the result of a metastatic lesion from within, such as the thrombophlebitis of typhoid fever or of pneumonia or the result of involvement by continuity from a neighboring infection such as a staphylococcic or streptococcic infection of the skin or an open wound. Chills and fever may accompany the local findings and a positive blood culture definitely establishes the nature of the lesion. The diagnosis of infectious thrombophlebitis should not be definitely made on the presence alone of thrombosis of the vein and fever. Infectious thrombophlebitis may be diagnosed

From the Department of Surgery, Tulane University School of Medicine. A portion of paper entitled: "Surgical lesions of the venous system; with particular reference to treatment" and read before the Hartford Medical Society, October 7, 1940.

only when in addition to these conditions a positive blood culture is found. The existence of such a lesion demands heroic treatment with modern chemotherapy, multiple blood transfusions and actual attack on the lesion by ligating the vein above it or excision of an entire segment of vein.

Thrombophlebitis may occur as a result of trauma even to normal veins. A direct blow over the external or internal saphenous vein may injure the intima sufficiently to produce thrombosis. Traumatic thrombophlebitis is usually mild but may progress by propagation even to larger radicles and the danger of emboli, while not great, is not to be overlooked. It is usually the mildest type of thrombophlebitis. Its occurrence is most frequent in young healthy individuals. It may remain localized in a segment of the vein within several centimeters of the initial thrombosis. This cause for thrombophlebitis is also a factor in the thrombosis occurring in varicosities. Traumatic thrombophlebitis may be afebrile and this, together with the usually relatively mild local symptoms, is the reason many patients remain ambulatory and largely disregard its presence. Neglected cases of thrombophlebitis of traumatic origin may result in induration and chronic passive congestion in the leg and, if the patient continues to walk without some support to the extremity, the result may be chronic induration and permanent damage of the tissues in an area where subcutaneous scarring may predispose to ulceration and infection. For this reason, patients with traumatic thrombophlebitis after the initial period of treatment should support the extremity with a bandage (ace, tensor or elastoplast. If prolonged support is necessary, a lastex stocking may be used.

Thrombophlebitis may occur as a complication of varicosities. This complication is not infrequent, and in some instances it may be a dangerous one. The thrombophlebitis occurring in varicose veins frequently manifest itself to the patient as a painful vein which has become hard. Systemically there may be a fever from 99 to 100 degrees Fahrenheit. The pain may be associated with local swelling or swelling in the region of the ankle. On the other hand mild grades of thrombophlebitis extending over a segment of several centimeters may cause the patient so little discomfort that they do not seek medical advice. The tendency of thrombi which develop spontaneously or as the result of trauma in varicose veins is to propagate, particularly if the varicosities are large. The thrombosis may progress

from the region of the calf up the internal saphenous vein to the fossa ovalis. When an extensive thrombosis occurs fever may be as high as 101 or 102, even though the lesion is not bacteriogenic. Swelling and pain may be very marked. This is one type of thrombophlebitis that is benefitted by transection and ligation of the vein above the thrombophlebitis. Because of the varicose state, unless there has been some pre-existing thrombophlebitis of the deep vein resulting in a compromised deep circulation, the treatment indicated is ligation and transection of the saphenous and its regional tributaries high at the fossa ovalis. Not only will this stop the progress of the thrombus but the local and systemic symptoms quickly abate and at the same time the varicosities are thus treated by the best possible means. Their chance of remaining well is exceedingly good.

Among the many measures advocated for the treatment of thrombophlebitis are: (1) Rest and elevation; (2) Heat or cold; (3) Support of the extremity and exercise; (4) Leeches and Hirudin; (5) Heparin; (6) Sympathetic nerve block with novocain; (7) Intermittent venous occlusion; (8) Operation.

Rest and elevation of the extremity with partial immobilization in cotton batting and bandage is probably the most commonly used therapy. It is an important adjunct therapy to some more effective measures. Heat is usually applied in the form of a heat tent or hot water bag or electric pad. Less frequently has cold been advocated as a measure for the treatment of this condition. Support and exercise has been advised in contradistinction to the rest form of therapy. In this type of treatment the extremity and involved veins are supported by a bandage of the ace or tensor type. The patient is then permitted to walk with the idea that the increase in circulation resulting from muscular activity will obviate any further propagation of the thrombus and lessen the danger of pulmonary embolism. This form of therapy is used to advantage in thrombophlebitis chemically induced in the treatment of varicose veins, the thrombophlebitis of sclerosing solutions. It is also very helpful in milder forms of thrombophlebitis, particularly those resulting from trauma. Support to the extremity by some sort of bandage is indicated in the treatment of all forms of thrombophlebitis in the latter stages. Too frequently after the patient has recovered from the acute stage they are permitted to be up with daily swelling of the lower extremity. If this swelling is permitted

to recur daily scarring in the subcutaneous tissue is the result and repeated swelling predisposes to the easier recurrence of edema. To prevent edema and scarring the patient should always be instructed to remain within his vascular reserve. If the circulation is deficient because of a recent thrombosis of the vein the patient should not be permitted to be up for a longer period than can be passed without any appreciable swelling. Wearing a supportive bandage will permit the patient longer periods of activity and reduce the dangers of permanently indurated and pigmented tissues in the region of the ankle with its susceptibility to infection and ulceration. Bandages should be worn too long rather than too short a time. After a period of thrombophlebitis organization and recanalization of thrombus is not complete for at least a month and therefore supportive bandages should be worn for that length of time, or longer.

Leeches and Hirudin are effective and rational measures of treatment of phlebitis. Leeches were used empirically and were very popular in the eighteenth century. Though their abuse almost abolished their use by ethical practitioners, since the last decade they have been revived in the treatment of certain conditions on a more rational and physiologic basis. (Mahorner and Ochsner.) The leech secretes a substance, hirudin, which injected into the wound it makes with its tridate chitinous jaws prevents the blood in that area from coagulating. Presumably some of the hirudin enters the bloodstream of the host. Each leech when fresh contains about seven to eight milligrams of hirudin. This amount will render fifty to sixty centimeters of blood incoagulable. Hirudin not only prevents coagulation for a long period of time, (twenty-four hours), but it is the only substance known which when isolated in pure form and put into clotted blood will redissolve the blood, making it fluid again appearing entirely normal. A few crystals of hirudin in a test tube of clotted blood will result in the blood going back into solution. Other chemicals which dissolve blood so alter the cellular structure of the blood that it no longer appears normal. Heparin does not have this quality although it can prevent blood from coagulating if added before coagulation begins. Both are relatively nontoxic other than this effect. Hirudin appears to be a remarkable substance and it is unfortunate that a chemical of similar nature or a synthetic hirudin is not produced which could be injected into the circulation. The cost of the pure

hirudin is great. It is not on the market and sufficient mine its value when used.

Leeches are available and are of benefit in thrombophlebitis. (Mahorner and Ochsner.) Leeches intravenously are applied thus: The fresh medicinal leech is placed or coaxed into a large test tube. Two cubic centimeters of 5% solution of sugar in water is placed in test tube. The tube is then inverted over the place selected for the leech to bite. He follows the sugar water down and attaches himself to the skin. The test tube is then removed and another leech is likewise applied. Leeches are applied along the course of the vein, and in a zone from which veins are tributary to the vessel containing the thrombus. It is hoped that hirudin thus directly affects the thrombus. Six to ten leeches are applied the first day and depending on the systemic and local symptoms four to six fresh leeches are reapplied on the second or third day. The leeches are permitted to engorge and fall off which occurs in about forty-five minutes. Bleeding is controlled by a compression bandage. The benefits to be expected are subsidence of pain and rapid disappearance of fever and edema.

Heparin has been used intravenously particularly to prevent a thrombosis occurring at the site of operations on the arteries, such as embolectomy and actual experimental anastomosis of arteries. Heparin may be expected to prevent the propagation of a thrombus. It is administered intravenously and repeated daily, since its effect quickly wears off. (Murray and Best.) It cannot be expected to alter the pre-existing thrombus.

Another measure which has been advocated for the treatment of thrombophlebitis is the release of vasoconstrictor effect of the sympathetic nerves by novocain injection. This method, proposed by Leriche and developed by Ochsner and DeBakey, is in wide use today and is a very helpful means of combating many of the symptoms of thrombophlebitis. The rationale of the method is best explained by the results of experimental work which was done by Ochsner and DeBakey at Tulane University. They showed that if a segment of vein was isolated in the dog and a thrombus was induced by a sclerosing solution it resulted in a vasospasm of the vessels of the entire extremity demonstrable by plethysmography. If sympathectomy had been done previously a vasoconstrictor effect was not found after injection of the sclerosing solution into the vein. Furthermore, if the sympathetics were blocked by injecting procaine

around the vessels containing the thrombus the vasospasm of the entire extremity was released. The effect of novocain block of the lumbar or stellate sympathetic ganglia when a thrombophlebitis is present in the respective extremity is: relief of pain; prompt reduction of the amount of edema; and abatement of the febrile systemic reaction. The course of the disease is shortened. The injection is made by directing 22 gauge needles toward the lumbar vertebral transverse processes, entering the skin two finger breadths lateral to the spinous process. After engaging the transverse process of the vertebra the needle is redirected and passed beyond it for a distance of two finger breadths. The needles lie between the first and second, second and third, third and fourth, fourth and fifth, lumbar transverse processes. Five centimeters of one per cent procaine are introduced through each needle. Thus the ganglia and vicinity may be infiltrated with procaine. The immediate effects are increase in temperature of the extremity and relatively prompt relief of pain. The sympathetic nerves should be reblocked daily or on alternate days, the procedure repeated depending on the systemic and local symptoms. If the symptoms abate and remain insignificant additional blocks will not have to be made, but if the temperature is elevated and the local symptoms persist, reinjection should be made. The average number of injections per patient is between one and two. Rarely is it necessary to repeat the injections more than three times. Not only does sympathetic release help the recent case, it also is of value in longstanding venous obstruction with edema and subjective discomfort.

Intermittent venous occlusion as advocated by Paine and Levitt may have an effect similar to that resulting from blocking the sympathetic ganglia with novocain. These authors report good results even in long standing cases of thrombophlebitis with disappearance of edema and prompt improvement in local and systemic symptoms. This method apparently is not in as wide use as some of the other measures mentioned above.

The measures offering the greatest relief in post-operative thrombophlebitis are sympathetic block of the ganglia, the use of leeches and Heparin. These may be used in conjunction with each other or independently. Occasionally the refusal of a patient to accept a block or the leeches will determine the type of therapy which can be used. The failure of one method in an individual case may make one resort

to the other measure. Infectious thrombophlebitis proven by positive blood culture is indication for immediate ligation of the vein above the infected thrombus even though it may be the iliac vein. Patients who otherwise seem hopelessly doomed from an uncontrollable blood stream infection may be saved by this radical measure. Traumatic thrombophlebitis, provided it is mild, may be treated ambulatory with supporting bandages and reduced activity. However, systemic symptoms and an extensive thrombophlebitis resulting from an initial trauma may indicate more radical treatment. Removal of the supportive bandages too early may result in delayed danger of daily recurring edema and chronic scarring. In varicose veins thrombophlebitis may best be treated, not by sympathetic block or leeches, but by actual ligation and transsection of the vein as was advocated by Edwards. This has been done by us in a number of instances with gratifying results in each case. The thrombus usually progresses to the point of ligation and after a few days the patient is in the same state as he would be had his varicosities been initially treated by ligation and simultaneous injection of sclerosing solution. Thus his varicose veins and thrombophlebitis are cured simultaneously.

Though it is not as well known as thrombosis of the axillary vein called "effort thrombosis" following efforts such as throwing or straining, a similar condition occurs in the iliac vein of the lower extremity. Within the last few months I have seen four patients all in the second or third decade of life, who, apparently well in every other respect, developed a swelling of the lower extremity on one side for no definitely explainable reason. The edema was associated in some with a sharp pain following an unusual exertion such as ballet dancing and tennis. Each of these young people with persistent unexplained swelling of the extremity, had continued ambulatory tending their duties. The edema from this condition is frequently more marked in the thigh than in the lower leg. There is little or no fever associated with it and tenderness may be found in the earlier stages above Poupart's ligament and over the course of the iliac vein. The patient notices that the swelling is more prominent after they have been on their feet for the entire day. The treatment of this condition is not standardized. Undoubtedly rest and time are the basic elements in the treatment but other measures are of value. Release of vasoconstrictor effect of sympathetic nerves by novocain block

usually results in resolution of the process and cure. In one of these instances in which the edema did not subside I explored the iliac veing retroperitoneally through an incision above the Poupart's ligament and crest of the ilium. A venolysis was done with subsidence of the edema. Even though the patient had been confined to bed for days prior to this operation the dramatic improvement in the swelling following it left little doubt that the operation had accomplished something for him. The prognosis in these conditions if neglected is extremely grave. If the patient with the effort thrombosis is permitted to be ambulatory with the leg unsupported and with the edema recurring day after day, after a period of months to years the tissues around the ankle will be indurated and pigmented and scarring will be so firmly fixed that they cannot remain on their feet longer than a few hours without the occurrence of more swelling. The slightest trauma then may initiate severe streptococcic cellulitis of the skin and eventually, if neglected, ulceration develops. Many of these patients do not undergo the proper treatment in the initial stage, the important stage for a real cure. They should have a prolonged rest. If neglected, they eventually become permanently partially disabled living a restricted life. The real convalescent period from such a thrombosis is from six months to a year. During all this time patients must protect their extremity and stay ambulatory only so long as they are without edema. The circulation gradually compensates and activity may be increased. Improvement may continue for as long as a year. Effort thrombosis must be differentiated from lymphatic obstruction either from congenital causes or recurrent cellulitis. A streptococcus cellulitis beginning in the skin of the lower leg frequently progresses with mild recurrent attacks until the whole leg becomes brawny and indurated. Undoubtedly obstruction of the lymphatic vessels in

these instances is the cause of the induration. The edema of the lymphatic obstruction is very much harder and more persistent than that of venous obstruction at the base of the leg. The absence of a history of a thrombophlebitis and the pain associated with it are other significant features in the differential diagnosis of the two conditions. An acquired lymphadema from streptococcic cellulitis is frequently associated with severe acute erysipeloid inflammations. Inflammatory lesions of this type may be secondarily superimposed on the edema resulting from an effort thrombosis but such are not easily confused with the primary lymphadematous swelling of the extremity.

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CONNECTICUT MEDICAL BIBLIOGRAPHY

WALTER R. STEINER, M.D., *Hartford*

THE HISTORIES of medicine in the different states in our country have been published in about fourteen instances.¹ Different phases in the histories of the different states however seem to have appeared more frequently, and among them the beginnings of medicine in Connecticut have been well portrayed by Doctor Gurdon W. Russell of Hartford² in a paper he read at the 100th Anniversary of the founding of our Society. Previously, in a Presidential Address in 1851, some of the early physicians of Connecticut had been entertainingly described by Doctor George Sumner of Hartford.³ I have also described somewhat the period in the chapter on the History of Medicine in Connecticut which I wrote for Osborn's History of our State.⁴ The beginnings of medical practice in one of the counties (New Haven) have likewise been entertainingly written by Doctor Herbert Thoms⁵ of New Haven, and some who have followed the science and art of medicine in those early times have been given to us by a number of writers, for brief biographies exist of John Winthrop, Jr., of Hartford,⁶ Gershom Bulkely, of Rocky Hill,⁷ Phineas Fiske, of Haddam,⁸ Jared Eliot, of Clinton,⁹ Benjamin Gale, of Clinton,¹⁰ Philip Turner, of Norwich,¹¹ Abigence Waldo, of Pomfret,¹² Elisha Perkins, of Plainfield,¹³ Elihu Hubbard Smith, of Wethersfield,¹⁴ and Thomas Young of Sharon.¹⁵

Before we list some of the other doctors of the pre-Revolutionary, Revolutionary and post-Revolutionary periods, we must not neglect to mention the name of Bryan Rossiter, a somewhat litigious person who forsook a practice in Windsor for one possibly more lucrative in Guilford, and was called to Windsor on March 28, 1661-62 to perform an autopsy on Kelly's child who was thought to have been bewitched by Goody Ayers. In the protocol of the autopsy, he gives six points which he considered supernatural.¹⁶ I have already mentioned Jared Eliot,¹⁷ but the name certainly deserves repeating, for he has been considered the father of medical practice in Connecticut. He was a clergyman, a physician and an agriculturist. He was also a scientist of the first order and was elected a Fellow of the Royal Society in London. On one occasion he told one of the men working under him that, if he would make a bar of iron out of common sea sand, he would give him a barrel of rum. "Such," said President Gilman, "was the

This issue of THE JOURNAL marks the presentation of the first of a series of special articles dealing with Connecticut's medical history. Others of this series planned in connection with our Society's Sesquicentennial will appear in subsequent issues and at a later date it is hoped to present these chapters in the permanent form of a memorial volume.

It is particularly fitting that the inauguration should be presented by so eminent a historian as Doctor Steiner. Not only is this first chapter a stimulating document of Connecticut's fine medical heritage, but the appended source references represent a signal contribution to our bibliography.

spirit which stimulated research in those days."¹⁸ Benjamin Franklin often stopped off to spend an evening with him at his home in Clinton while Franklin was journeying on the post road to Boston, and on one occasion Franklin said he would gladly exchange some of his old and rare folios for the opportunity of spending an evening with Eliot, in order to listen to Eliot's delightful stories.¹⁹ Lyman Hall was born in Wallingford, and after graduating from Yale became a minister of the Congregational Church in Stratfield (Bridgeport), but getting into some difficulty with the Church leaders, was dismissed a year later and subsequently practiced in Wallingford. Finally, about 1756, he removed to South Carolina, but soon migrated to Georgia where he signed the Declaration of Independence, was sent to Congress and eventually was elected Governor there for a year's term.²⁰

In 1903, Sir William Osler rehabilitated Doctor Hezekiah Beardsley who practiced medicine in New Haven, Southington and Hartford, and while in Southington performed an autopsy upon a child with congenital hypertrophic stenosis of the pylorus.²¹ This was supposed to have been the first reported case of the condition in the literature, but subsequently two earlier ones have been discovered. Doctor Philip Turner of Norwich was a very skillful surgeon, and during the Revolutionary War, he held the position of Surgeon of the Hospital Eastern Department. He also had a private medical school before any chartered schools were established,²² just as Doctor Lemuel Hopkins of Hartford had a celebrated one which he refers to as saying "he kept a room full of pupils." Lemuel Hopkins had many activities besides this medical school, as he was one of the Hartford Wits and contributed to a number of their poetical productions. He also wrote a number of poems which still survive, the one on the Cancer Quack being the best known. We have his manuscript treatises on Consumption and the Common Cold or Catarrh in the Library of the Hartford Medical Society. His treatise on Consumption was remarkable for those times as he believed it was preventable in its early as well as its chronic stage, which he stated in these words:

"But if anyone aspires to gather laurels in this barren, ghostly field of practice he must be studious, critically observant of symptoms, inventive, copious in resources, persuasive with his patients and persevering in his endeavors. 'In this way,' he adds, 'I have no doubt but many may recover from an early stage of phthisis, in some instances perhaps the emaciated hectic may return as it were from the tomb'."²³

We regret that we have so little at present to tell about Doctor Simeon Smith of Sharon, who intended, before the Revolution, to found a medical school in Connecticut on the lines of the Edinburgh school, as well as a hospital similar to the Edinburgh Royal Infirmary.²⁴ We hope to be able to write more about him later.

Coming down to the date of the founding of the Connecticut State Medical Society, Doctor Ashbel Woodward of Franklin, a Past-President, appears to have been the first one to write on the Society's early beginnings

and past history.²⁵ His article appears in our State Transactions for 1859. Some years later, in 1873, Doctor Henry Bronson of New Haven,²⁶ another Past-President, gave another account, and still later at our 100th Anniversary in 1892, Doctor Francis Bacon also from New Haven, a third Past-President, gave us still another.²⁷ Five years later the history was well discussed by a fourth Past-President, Doctor N. E. Wordin of Bridgeport, in Volume II of *The New England States*.²⁸ Some years previously, Doctor Julian La-Pierre of Norwich discussed the conception of our State Society in an address which he gave before the New London County Medical Association which was subsequently printed in our State Transactions for 1893.²⁹

Locally the histories of the eight component County Medical Associations in our State Society have not been neglected, for Doctor Henry Bronson has described the origin of the New Haven County Medical Association and has given very important data about the medical profession when that Association was organized.³⁰ It published the first Transactions of any of the Associations in 1788.³¹ Later, in 1902, Doctor Gustavus Eliot of New Haven gave a briefer description of this Association's origin, along with a valuable list of its members.³² At its 150th Anniversary in 1934 various historical papers were read which afterwards appeared in the *Yale Journal of Biology and Medicine*³³ and were also published separately. Forty-two years previously, Doctor Joseph E. Root of Hartford³⁴ gave a similar attention to the history of the Hartford County Medical Association, while at the 100th Anniversary meeting of the Fairfield County Medical Association, Doctor W. C. Wile of Danbury discussed Medicine in Colonial Connecticut, paying some attention to the physicians in that county, and Doctor W. G. Bronson of Noroton gave us some reminiscences of the early practitioners in that county. These addresses were published in a pamphlet which later appeared, together with valuable biographical sketches of some of the prominent members of the Fairfield County Medical Association.³⁵ Previously, Doctor R. Blakeman of Greenfield had described some early physicians of Fairfield County, which appeared in the State Transactions for 1853.³⁶ Doctor J. C. Kendall of Norfolk later, on two separate occasions, described the Litchfield County Medical Association,³⁷ but its origin was wrapped in obscurity until my paper, which was published in the *Yale Journal of Biology and Medicine* in 1936, showed that it was established in 1779.³⁸ The beginnings of the New London County Medical Association have not been described, but the efforts of eleven local physicians residing in Norwich in that County deserve the highest praise, for they attempted in 1763 to start a State Society, but without success.³⁹ Doctor A. Woodward gave some biographical sketches of the early physicians in Norwich in 1862.⁴⁰ Besides this article, he was also the author of a good biography of General Lyon of Connecticut birth who saved Missouri for the Union,⁴¹ of a history of his native town of Franklin, Connecticut,⁴² and finally of an interesting article on Wampum, the Indian form of money.⁴³ No account of the origin of Tolland County exists, but Doctor Charles F. Sumner of Bolton has de-

scribed the early physicians of that County in 1871,⁴⁴ while Doctor M. Hazen of Haddam in 1892 gave us the centennial history of the Middlesex County Medical Association,⁴⁵ and previously some historical sketches of their original members had been given by Doctor R. W. Mathewson of Durham in 1877.⁴⁶ In 1907 Doctor Hazen also described some of the earlier practitioners of Haddam.⁴⁷ Unfortunately, Windham County appears to have been unwept, unhonored and unsung, and will be fertile field for future investigators.

The son of Doctor Nathan Strong, the pastor of Center Church, Hartford, deserves recognition, for in 1810, a year before the publication of Doctor Elisha North's book on Epidemic Cerebrospinal Meningitis, Strong published an inaugural dissertation upon this subject to gain admission to the Connecticut State Medical Society.⁴⁸ I endeavored some years ago to give a short account of his life, but found his later period wrapped in much obscurity. Doctor Elisha North of Goshen and New London, besides publishing the first book in the world on the above mentioned subject (1811), was also prominent as an early vaccinator in Connecticut, not long after the time of Doctor John Crawford of Baltimore and Doctor Benjamin Waterhouse of Boston, who were the first to pursue this practice in this country. He is also to be remembered as the founder in New London in 1817 of the first Eye Infirmary in the United States.⁴⁹

The Yale Medical School was established in 1813, and among the doctors prominent in the early years of its origin was Doctor Eli Ives, who has been well discussed by Doctor Henry Bronson⁵⁰ and Doctor George Blumer⁵¹ both of New Haven; Doctor Jonathan Knight by Doctor H. Saxton Burr⁵² of New Haven, and Doctor Nathan Smith in a volume devoted to his biography by Mrs. Alan P. Smith⁵³ who married his grandson in Baltimore. Doctor Smith, who held so many chairs at the foundation of the Yale Medical School that one of the Boston pundits called them a "settee", created a sensation when he published his small volume in 1824 on Typhus or Typhoid Fever, in which he advised the cold bath treatment which was popular until the last few decades, although it was early abandoned only to be revived again by Brand in Germany in 1880. By this treatment he would sit the patient up in bed and pour three to four buckets of cold water upon him. "When this is done," he naively adds, "it is better he should lie on a straw bed. It is not however essential."⁵⁴ Posthumously his distinguished son, Nathan Ryno Smith of Baltimore, published a memoir⁵⁵ of him some years after his death. In it were included his father's classic article on Bone Necrosis, and another on his popular Anterior Splint for Fractures of the Femur. Doctor Francis Bacon tells us that when the Class of 1829 presented to Smith his painting by Samuel F. B. Morse the inventor of the telegraph, that Doctor S. J. Johnson, one of the Committee, said many years later that Doctor Smith exclaimed: "Set it down, gentlemen," rather grimly, "its an excellent likeness." And then, with a twinkle, "Its as ugly as the witch of Endor."⁵⁶ Doctor Jonathan Knight, above mentioned, was long a Professor

of Anatomy and Surgery at Yale. He is responsible for two addresses from his scanty store of writings, on the early history of the Yale Medical School,⁵⁷ and also of a eulogy on Doctor Nathan Smith.⁵⁸ We regret that we have not sufficient data on Encas Munson. Examples of his keen, dry, biting wit are still extant, which he regretted but could not help. He was too old at the foundation of the Yale Medical School to do any teaching, but the original Faculty desired the use of his name as he was so prominent in the medical profession. In the early history of the nineteenth century, Doctor Mason Fitch Cogswell has been described as a remarkable surgeon in Hartford.⁵⁹ He was one of the early ones who tied the common carotid. At the beginning of the Yale Medical School he was appointed Professor of Surgery, but when he learned that Doctor Nathan Smith of Hanover could be secured, he gracefully retired. I have elsewhere written briefly about the other doctors who were among the first professors there, as well as a history of the school's origin.⁶⁰ Doctor Worthington Hooker,⁶¹ a general practitioner of Norwich, later became Professor of Medicine at Yale. He was the author of many books on medical subjects, including juvenile textbooks. Among them we may mention those on Medical Delusions,⁶² Homeopathy,⁶³ Physician and Patient,⁶⁴ Rational Therapeutics⁶⁵ and Human Physiology.⁶⁶

In 1824 when the Hartford Retreat was founded by the Connecticut State Medical Society, Doctor Eli Todd of Farmington was appointed the first Superintendent. His fame seems well secured. Doctor Charles W. Page of Hartford⁶⁷ has appropriately described his life, as well as Doctor Henry P. Stearns,⁶⁸ a former Superintendent of the Retreat, who wrote on Doctor Todd in one of its Annual Reports. Doctor Stearns was also the author of three volumes: one on Medical Examinations for Life Insurance,⁶⁹ another on Insanity: Its Causes and Preventions,⁷⁰ and the third, a volume of lectures on Mental Diseases,⁷¹ designed especially for medical students, they were the lectures which he delivered at Yale. He was also the author of a short article on Horace Wells. Doctor Charles W. Page was likewise connected with the Hartford Retreat, and the author of a book on The Care of the Insane and Hospital Management,⁷² was at one time the Superintendent of the Hospital for the Insane at Middletown, and served also during two periods as Superintendent at the Hospital for the Insane at Danvers, Massachusetts.

Doctor Thomas Miner of Middletown⁷³ was elected President of the Connecticut State Medical Society in 1834, and was a physician of great culture. Ill health prevented his practice of medicine later in life, but he made a number of translations from foreign languages on medical subjects, and wrote a book on Fever⁷⁴ with the learned Doctor William Tully of New Haven⁷⁵ who was, as Ferris calls him, "a peripatetic physician," practicing in many places. He held the position of Professor of Materia Medica at Yale for ten years, but was in the habit of resigning yearly, and at the end of this time was greatly disappointed by the Yale Faculty accepting his resignation. He was said never to have been the same after that. William Alexander

Alcott was born in Wolcott, Connecticut, in 1798. He resembled Henry Barnard in being an educator, which came to him naturally after many years of teaching. He was also a physician blessed with a great amount of common sense, and after many years of experience he wrote an autobiography with the quaint title: "Forty Years in the Wilderness of Pills and Powders." He published in all about one hundred books and pamphlets dealing with education, morals and physical training. He seems to have anticipated the medical inspection of schools and other important reforms. He died in Auburndale, Massachusetts, on March 29, 1859.⁷⁶

Doctor Ebenezer K. Hunt⁷⁷ was a distinguished Hartford physician in whose memory his widow gave the home of the Hartford Medical Society which is known as the Hunt Memorial Building. He translated Esquirol's volume on Insanity,⁷⁸ making some important additions to it. Doctor Francis Bacon of New Haven, courtly, even majestic in figure, a true gentleman of the old school whose commanding presence still lingers in my memory, had a charming style distinguished by its felicity of expression and Gallic lucidity. In 1903 when the New Haven Medical Association had their centennial celebration, he gave the first address, which unfortunately has not been preserved, while Sir William Osler followed with an address on the Educational Value of a Medical Society. Doctor Bacon was also the author of an address on Sir Thomas Browne who wrote *Religio Medici*, which also has disappeared. Doctor William H. Carmalt of New Haven⁷⁹ was our grand old man in medicine for many years. He was rugged in his honesty, frequently gruff in his actions, oftentimes pronounced in his views and fearless in his enunciation of them, but with it all we shall rarely see his like again as he was greatly beloved by all of us. He held the Professorship of Surgery at the Yale Medical School, and those who served on his Service in the New Haven Hospital frequently refer to that distinction. His knowledge of cancer was most profound, and his clinical lectures at the Yale Medical School make interesting reading, for he was well versed in the science and art of surgery. Among other distinguished names, we should mention Doctor James Gates Percival of New Haven,⁸⁰ physician, poet and geologist; Doctor William Beaumont⁸¹ a doctor of Connecticut birth whose epoch-making researches in the study of gastric digestion have given him world wide fame; and Doctor Malines Conkling Leavenworth of Waterbury⁸² a well known botanist. Although not a physician, the name of Noah Webster of New Haven⁸³ should be included, as he was Connecticut's first epidemiologist. And coming down to our time, the fame of Doctor William H. Welch of Baltimore⁸⁴ still sheds lustre upon his Connecticut origin.

In a consideration of the medical profession in certain localities in Connecticut, Doctors Sumner and Russell of Hartford⁸⁵ have given us sketches of some of the physicians in their town in 1820 and 1839, and Doctor Francis Bacon of New Haven has given some account of the profession there in a volume published in 1887.⁸⁶

Different members of the Connecticut State Medical Society have made valuable contributions to what has been done in the State along medical lines, for Doctor H. B. Ferris of New Haven has written about medical education and public welfare in Connecticut,⁸⁷ while Doctor E. K. Hunt of Hartford⁸⁸ has described the public and benevolent institutions and movements with which the Connecticut State Medical Society has been prominently identified,⁸⁹ and Doctor Ferris has also entertainingly depicted the medical teachers in the State, paying especial attention to Doctor William Tully.⁹⁰ The sanitary question in Connecticut has been considered by Doctor Lindsley of New Haven when he wrote about the Beginnings and Growth of Sanitary Conditions in Connecticut in the 1892 Transactions,⁹¹ while many years later Doctor C. E.-A. Winslow of New Haven considered the Health Legislation in Colonial Connecticut⁹² and the Development of the Public Health Movement⁹³ in this State in two valuable articles. The epidemic diseases in early Connecticut times have been well described in the Presidential Address of Doctor Charles B. Graves of New London in 1920.⁹⁴ Thus, in evaluating the work done by the physicians in Connecticut, we find they have been very active in promoting the public good in many particulars.

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This is merely a preliminary list which is a pioneer one, and naturally there are left out a number of references which should be included. The necessary additions may appear in future editions. Although more than one reference might be given, I have tried to limit them to one, after the first reference.

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I have made no reference to Amariah Brigham because he practiced in Connecticut for only eleven years, during two of them being Superintendent of the Hartford Retreat. He might well be included, however, because he was the author of a number of books, and later attained great distinction as founder of the New York Insane Asylum at Utica, and as Editor of the American Journal of Insanity. (Hunt. In Gross' Lives of Eminent American Physicians and Surgeons of the Nineteenth Century, 1860, 521-544.)

ON THE NATURE AND TREATMENT OF EPILEPSY

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The clinical picture of epilepsy:

THE MORE striking phenomena of epilepsy, and the general natural history of the disease, have been known to the medical profession since before the time of Hippocrates. They are fairly well described in most standard text books, which, however, often fail to emphasize important points of more recent acquisition.

One of these is the high incidence and economic importance of the disease. About as many people suffer with convulsions as suffer from diabetes or active tuberculosis. Approximately 40,000 are housed in public institutions at a yearly cost of about \$18,000,000.¹ The problem is, therefore, one to be taken seriously.

Another aspect of the disease which has recently received attention is the great variability of pattern of attacks. The standard classification of grand mal, petit mal, and psychomotor attacks is fairly familiar. Attacks of "vasovagal"² or autonomic type³ have also been well described. Others have been recognized in which the attack consists in a spontaneous, fleeting, vivid, emotional experience—a brief elation or depression—or some complicated compulsive act.⁴ In infants, attacks may apparently take the form of violent digestive upset, for which no other explanation may be found.⁵ A review of the subject of epileptic deterioration shows that in many, perhaps the majority of instances, the chronic intellectual impairment is actually due to a continuous physiologic disturbance of the cortex, which is often relieved by adequate treatment.⁶

Recent physiological investigations:

An intensive study of convulsions by physiological means has been undertaken in several laboratories.^{7,8,9,10} The results of these investigations will unquestionably bear fruit in treatment some time in the future. Already they have shown the way to an increased diagnostic accuracy, obtainable by the use of electroencephalography in puzzling cases.^{8,9} This

technique permits an accurate differential diagnosis to be made in many instances between such entities as hysteria, syncope, and behavior disorders on the one hand, and the convulsive state on the other.⁷ It has given a new method of classification of types of seizures, which often points the way to a more effective treatment.⁷ Finally, it is of considerable use in the localization of focal lesions such as tumors.⁸ Doubtless still other uses will be found for it.

An outline of management of cases in which convulsions are the presenting symptom:

Most physicians have at their finger-tips a concise scheme for the routine handling of uncomplicated cases, say of diabetes or of gastric ulcer. Policy in regard to epilepsy is far less standardized. The following outline is suggested as a routine, to be modified profoundly, of course, if circumstances demand it.

A patient seen for the first time after a few attacks should practically always be hospitalized for special studies. Hospitalization is primarily for the purpose of ruling out brain tumor, or other gross organic disease of the brain, and metabolic disorders. It may often be dispensed with in the case of a patient who has had repeated seizures of a similar pattern over many years, without developing other manifestations of disease of the nervous system.

On hospitalization, or at the first contact with the patient, a detailed history should be obtained, which above all things should include a list or chart of attacks, with full notes as to the treatment (if any) being given at each stage of the disease. Typical attacks should be accurately described, and a study made of apparent precipitating events. Naturally, a routine medical and neurological history should be recorded.

The general medical and neurological examination need little comment. It is, of course, common to find minor abnormalities such as a fine nystagmus, asymmetry of the face, inequality in reflexes, etc. in the neurological examination of patients suffering from seizures.¹¹

A spinal puncture should be performed routinely. A normal pressure under basal conditions, and a nor-

mal protein content constitute presumptive evidence against brain tumor.¹²

X-rays of the skull are easily taken, and while they seldom give important information, the occasional case in which they make the diagnosis justifies the trouble.

A determination of the blood sugar is essential if the attacks tend to occur only at long intervals after meals. Studies of blood chemistry are otherwise seldom revealing.

As has been suggested, electroencephalography in the hands of an expert often gives extremely important information. The apparatus is now available in most large cities.

Should pneumoencephalography be routinely employed? If an operation on the brain seems possibly indicated, it doubtless should be. The pain and danger to the patient and trouble to the doctor may well be spared, however, if it is perfectly clear on other grounds that medical treatment is to be tried, even if only as a therapeutic test.

It is usually wise in fresh cases to institute a regime of medication before the patient leaves the hospital.

The entire period of primary hospitalization should take less than a week, often as little as two or three days. Rehospitalization may be indicated if new symptoms occur, or if the patient does not respond satisfactorily to treatment.

Methods of treatment of "idiopathic" epilepsy:

In the great majority of cases seen in private practice or in a medical clinic, no evidence of gross organic disease are found. The problem then is, how to safeguard the patient, and what treatment to give him. It is usually wisest to tell the patient that during a probationary period of at least a year, he cannot be sure of being free from attacks, no matter what treatment is given. Under certain circumstances—for example, in the case of a child at school, a chauffeur, or an actor—it is best for him to retire from his routine environment for a period of months, to be sure to avoid disaster or embarrassment while a routine of treatment is being established. During the probationary period, patients should refrain from driving an automobile, working near heavy machinery, riding horses, or bathing alone. Other prohibitions will suggest themselves in special cases. The risk of being run over during an attack in the street is statistically small. Surprisingly few patients injure themselves severely during

attacks, and in the majority of instances, damage when it does occur, results from falling downstairs, against radiators, etc.,—risks which can scarcely be avoided. Patients are apt to become desperate or disobedient if too many limitations are placed upon their lives.

The medical treatment of convulsions:

The most generally useful form of treatment of epilepsy at present is the administration of anticonvulsant medicines. They should be tried in practically every case: they are effective in over 80% of fresh "idiopathic" cases.

Bromides are usually less effective and more likely to produce disagreeable symptoms than phenobarbital or dilantin.¹³ They are now little used in most specialized clinics.

Phenobarbital is the standard anticonvulsant drug, and is often effective. It is worth trying in most cases of grand mal, since it is available everywhere; its effects are well known and overdosage produces symptoms easily recognized by the patient. Purchased as tablets of 0.1 gram in bottles of 1,000, it is the least expensive form of treatment known.

It has certain disadvantages, however. It is so seldom effective against petit mal and psychomotor attacks—at times even aggravating them—that it is scarcely worth a trial in such cases. In effective doses, it often produces an intellectual depression and drowsiness which is incapacitating to the patient. Finally, it is not infrequently employed for suicidal purposes, usually successfully.

Phenobarbital should be prescribed in doses of 0.1 gm. daily (for the average adult), and the dosage gradually increased until the patient is relieved or complains of drowsiness. Children tolerate high doses in proportion to weight.

The anticonvulsant properties of phenobarbital which were introduced as a hypnotic were observed by accident.¹⁴ In 1937, a systematic search by means of animal experiments was made in the hope of finding more effective anticonvulsant drugs.¹⁵ A whole series of promising substances was discovered,¹⁶ of which only one, sodium diphenyl hydantoinate, has progressed to the point of widespread clinical trial.¹⁷ It is now better known by its official name of dilantin sodium.¹⁸ It is a non-proprietary substance, accepted and named by the Council on Therapy of the American Medical Association.¹⁸

Dilantin has certain chemical and physical similarities with phenobarbital. It is effective only in the

form of the sodium salt, which is extremely alkaline and has a disagreeable taste. It is therefore given in sealed capsules, available in 0.1 gm. size.

Pharmacologically, dilantin is extremely effective in preventing the convulsions caused by passing an interrupted current through an animal's brain. In large doses, it produces unsteadiness and finally hypnosis in animals, but massive doses are usually survived.¹⁹

Dose for dose, dilantin is about as effective as phenobarbital in preventing grand mal convulsions in human beings, but is more effective against petit mal and psychomotor attacks. It has, however, usually slight or no hypnotic effect; indeed some subjects find it rather stimulating. For this reason, it can be given in larger doses than can phenobarbital—up to 0.6 daily. In practice, it is wise to start with a small amount, one or two capsules daily after meals, and increase gradually at intervals of 3-7 days, until the convulsions are controlled or disagreeable symptoms occur. If some anticonvulsant medication is being given, the two medicines should be overlapped for about a week. A common error is to give insufficient dilantin.

Toxic symptoms are not uncommon, but they are seldom alarming. The drug may produce gastric irritation. This can usually be controlled by giving it *during* a meal. Sometimes administration of hydrochloric acid is helpful in overcoming the irritation.

Other common symptoms are dizziness, headache, and tremors or restlessness. Skin rashes, occasionally with fever occur in children, and may be mistaken for the exanthemata. A benign hypertrophy of the gums occasionally occurs, especially in children. It has been confused with scurvy, though the two conditions have nothing in common.

Even more bizarre symptoms are rarely encountered: a striking increase in libido, excessive growth of hair, purpuric spots, exfoliative dermatitis, brief psychoses, increase of focal symptoms, etc.

In most instances, the toxic symptoms disappear when the dose is decreased slightly, and it may often be increased again in a few days. It is rarely necessary to omit it entirely, and doing so may precipitate a shower of attacks (as with phenobarbital).

Enormous doses (up to 45 capsules) have been ingested without permanent injury.²⁰ No fatalities are definitely known to have resulted from its use.

If a maximal dose of dilantin fails to control the attacks, phenobarbital may be added to the point of

causing drowsiness. No particular advantage is seen in adding caffeine or amphetamine to the medication.

As with phenobarbital, the administration of dilantin may be, and usually must be, continued indefinitely. Occasionally a small degree of tolerance develops, and the dose has to be increased. More often, its effectiveness increases with the passage of time. In many patients, the most striking change is the increase in alertness, and the disappearance of the "periodic dulness" which is the commonest variety of "epileptic deterioration." In an extraordinary case reported by Fabing,²¹ a patient of 23, who had made no intellectual progress since the onset of convulsions at the age of 6, was able to make up five years of school work in six months.

It is difficult to predict whether dilantin will be effective in a given case. In general, it is almost always worth a trial if other medicines fail, and before the use of the ketogenic diet or surgery. In a large series of cases, about 60% are relieved, about 80% improved. The proportion is higher if the medication is given early in the course of the disease.

Other forms of treatment—regime and diet:

While proper administration of medication is usually the most effective form of treatment of "idiopathic epilepsy", other measures should not be forgotten. An important point is regular, vigorous exercise. Patients should get themselves into hard athletic training; this step alone will relieve convulsions in occasional cases, and improve the sense of well-being in many others. Regular hours, leisurely meals and plenty of sleep are also to be recommended. In some cases, attacks are precipitated by hyperventilation, such as caused by playing wind instruments, violent exertion and the like; the remedy is obvious.

It is rarely necessary to prescribe a special diet. The ketogenic diet and drastic dehydration are measures which are occasionally successful, but so much more formidable than medical treatment that they need only be considered when maximal medication has failed, which is seldom.

Surgical treatment:

In a small proportion of cases (probably less than 1%), the presence of a focal lesion may be demonstrated by neurological examination, pneumoencephalography and electroencephalography. Often, however, there are multiple scars if one is found.

Surgical excision of focal lesions has resulted in

relief of seizures in a certain number of cases—less than 50% in large series followed over a long time. It is not always clear from many of the reports in the literature that no change was made in the level of medication after operation. The subject has been considered in another paper in the symposium, and need not be pursued further here.

Psychological treatment:

There are few chronic diseases which impose as heavy a psychological burden as does epilepsy. Patients invariably need comfort and encouragement. They do much better if they can return to some place in society. There is a great need for educational work among epileptics and the public at large, for the subject is deeply buried in a mass of mythology in the minds of most people. An excellent step in this direction has been made by the Laymen's League Against Epilepsy, office at 25 Shattuck Street, Boston, Massachusetts, and all patients should be urged to join.

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Venereal Disease and National Defense

The Assistant Surgeon General of the U. S. Public Health Service is urging all physicians to subscribe to "Venereal Disease Information," a monthly digest of the important papers on venereal disease from the entire world. Increasing demands on private physicians occasioned by the national defense program accents the need for reliable, current and usable information regarding venereal disease, according to Assistant Surgeon General R. A. Vonderlehr.

"Venereal Disease Information" is published monthly by the U. S. Public Health Service and is available at the subscription rate of fifty cents per year. Orders for subscriptions should be directed to the Superintendent of Documents, Government Printing Office, Washington, D. C.

Britain at this moment when she must realistically evaluate manpower and the costs of maintaining it, embarks upon a large-scale rehabilitation program for the tuberculous, essentially because the British experts in this field know that such a program saves far more than it costs. Siltzbach, *Tuber. San. Conf. of Met. N. Y.*, 1941.

The cost of discovering tuberculosis in a recruit and rejecting him from service is \$400. Burroughs and Frechette, *Jour. A. M. A.*, Oct. 19, 1940.

SYMPTOMS COMPELLING ATTENTION TO THE HEART

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THE COMPLETE UNDERSTANDING of any case depends upon three sets of evidence: a history of the symptomatology, a physical examination, and appropriate laboratory data. It is my task to discuss the first of this triad.

A symptom is an unpleasant sensation which arises in any organ whose function becomes deranged or impaired. In any analysis of symptoms we must first ask ourselves what it is that we wish to learn from symptoms. There are four types of information, which, it seems to me, symptoms could furnish: 1. Something about the patient's make-up and personality. 2. The organ to which the symptoms direct our attention. 3. The evolution of the symptoms. How did they begin? What factors induced them? How did they develop, and with what sequence? Are they worse now than at their inception? 4. Finally, to come to our subject of the heart, whether there are any special symptoms which are in themselves diagnostic and enable us to recognize and solve important problems early.

1. The patient's personality—

It should be recognized that a patient and his symptoms are one. Therefore, an acute doctor can gain an insight into his patient's mental make-up by close questioning about his symptoms. He learns quickly whether his patient is under an emotional strain or whether he is faced with great economic and physical burdens. He can determine whether his patient is hyperreactive to pain, or whether he is dull and hyposensitive; whether his patient is in fear, and whether he is withholding important information.

The physician should also remember that while he is questioning the patient, he is in turn being examined by the patient. Although no data is available on this point, it is my distinct impression that the confidence of the patient is gained during the period of history taking; in fact, a clear, precise

clarification of the patient's complaints by astute questioning lays the foundation for an enduring co-operation of the patient with his doctor. The moral, of course, is: "Spend plenty of time on the history; you will be well rewarded."

2. Symptoms directing attention—

TABLE I
COMMON SYMPTOMS IN HEART DISEASE

	ORGANIC HEART DISEASE	OFFICE CONSULTATION
1. Dyspnoea on exertion	87% (50)*	34%
2. Pain	46% (21)*	68%
3. Palpitations	17% (5)*	32%
4. Fatigue and exhaustion	28% (6)*	42%
5. Cough	21% (7)*	8%
6. Dizziness	14% (6)*	22%
7. Chills and fever	3% (2)*	1%
8. Syncope	1.	8.

*Indicates number with satisfactory description of symptoms.

Table I shows an analysis of 100 patients in the hospital,* admitted with a diagnosis of organic heart disease. It can be seen that the commonest symptom is dyspnoea, occurring in over 87% of all patients. The next most frequent is pain, in 46%, and the third is fatigue, in 28%; the fourth is palpitations, in 17%. Then there occur a variety of lesser symptoms arising not in the heart, but in other organs whose function is impaired by an inadequate circulation.

The asterisk marks the number of patients in whom the description of the symptom was at least 50% accurate. Even so, in many instances, there was a failure on the part of the historian to obtain a clear description of the nature of the symptom, how it developed and grew, and, in the case of pain, its character, location, distribution, and the exciting factors which induced it. With respect to pain, it is safe to say that it is least adequately described, although it can be most completely diagnostic when it is properly analyzed.

Fatigue was found described much less often than

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it should be from what we know of the effect of heart disease on muscular efficiency. It may be one of the earliest symptoms and often progresses to a feeling of exhaustion.

Finally, the palpitations were found less often and were rather poorly described. Since such symptoms often occur as the only evidence of a disordered heart, a clearer understanding of their nature is desirable.

In the second column are found symptoms of patients in office consultation who fear heart disease. It can be seen that dyspnoea caused by exertion occurs less often, while pain, palpitations, fatigue, dizziness and syncope occur in greater frequency. The lower incidence of dyspnoea suggests that many patients who fear heart disease do not have it, which, in fact, was true. The same may be said for the other symptoms. If then these symptoms occur in both cardiac and non-cardiac cases, it is essential to learn those of their special features which direct attention to the heart.

A. Dyspnoea—This symptom actually arises in the lungs and may be caused by pulmonary as well as cardiac disease. Nevertheless, in organic heart disease, it occurs in almost nine out of ten patients. In heart disease, however, shortness of breath is a reflex from an over-distended lung in which blood has accumulated because of a failing left ventricle or mitral stenosis. The dyspnoea is exertional, increasing with activity and subsiding with rest, not frequently associated with cough and expectoration. In pulmonary disease, however, dyspnoea is also aggravated by exertion, but is practically always accompanied by cough and free expectoration of mucous. The patients suffering from anxiety also complain of difficulty in breathing, but close inspection shows the trouble to be more of a sighing than dyspnoea. Sighing is not due to heart disease. In neurocirculatory asthenia patients may also show dyspnoea on exertion, but in addition a variety of other symptoms obviously of nervous origin.

In organic heart disease exertional dyspnoea is stationary if the degree of the heart damage remains unchanged and grows in severity if heart failure increases. More rarely, it develops suddenly, as in mitral stenosis with tachycardia, or coronary occlusion with left heart failure and pulmonary edema. Questioning should be directed to reveal whether the symptom has grown in severity or remained unchanged. Table II shows some conditions with disturbed respiration, and it should be noted that

- (1) there are stages in the progress of dyspnoea,
- (2) other causes besides the heart produce dyspnoea,
- (3) anxiety breathing of the sighing type directs our attention away from the heart and towards an emotional disturbance,
- (4) finally, Cheyne-Stokes breathing during the day is a grave prognostic sign.

TABLE II

DISORDERS OF RESPIRATION

1. Dyspnoea—or difficult breathing and orthopnoea—all aggravated by exercise and relieved by rest.
 - A. Cardiac—a reflex from lungs when they are engorged by left heart failure.
 - B. Pulmonary disease, mediastinal disease; bronchial spasm.
 - C. Diaphragmatic hernia, eventration, or paralysis.
 - D. Nervous affections.
2. Cardiac asthma and pulmonary edema—occurs when congestion of pulmonary circulation occurs suddenly, as in failure of left ventricle, and tachycardia in mitral stenosis.
3. Periodic apnoea and hypernoea—Cheyne-Stokes respiration—not pathognomonic of heart disease, but occurs most commonly in chronic heart disease with failing left ventricle when combined with poor blood supply to respiratory center, serious when present during waking hours.
4. Non-cardiac forms (anxiety state)—
 - A. Rapid breathing or slow breathing.
 - B. Sighing respiration.

B. Pain—The heart is supplied by sensory nerves which travel through the sympathetic trunks to the spinal cord, entering through the first to the fourth or fifth thoracic segments. All structures of the heart are innervated so that the irritation of the pericardium, myocardium, endocardium and vascular system sets up characteristic types of pain. When the blood supply to the myocardium becomes temporarily insufficient, as in angina of effort, or permanently obstructed, as in coronary occlusion, nerve endings either are irritated or die of anoxia and a characteristic type of pain results. Obviously, rest immediately relieves the irritation in angina of effort and the pain promptly subsides; and this fact characterizes the pain, induced by a certain amount of effort, promptly relieved by rest. In coronary occlusion, the irritation of the nerve endings is caused by permanent anoxia during which the pain continues until death of the nerve endings has occurred. The pain is therefore varyingly prolonged.

Aside from the pressure pain of aortic aneurysm or the constant pain in pericarditis or acute rheumatic myocarditis, the significant point about pain

arising in the heart as a result of coronary sclerosis is, first, that it is seldom true pain, but a squeezing, band-like oppression, tightness, or burning in the substernal region with radiation as is shown in Table IV, and that it is induced by effort and promptly relieved by rest. Slow relief, in which the pain lasts over half an hour should cause us to look for a coronary occlusion. The amount of effort that induced the "pain" is a fair measure of the degree of sclerosis. In questioning the patient about the amount of exertion that induces a pain now, as compared with months ago, it is possible to gain an insight into the rate at which the sclerosis has progressed. Occasionally the pain occurs more or less suddenly. In the latter instance a partial or complete closure of a vessel probably preceded the pain. It is not an uncommon story to hear a patient say he was perfectly well until one day, when, as he was walking against the wind or crossing the street, he was seized with his pain. It promptly subsided as he rested, but has recurred ever since, whenever the same amount of exertion is undertaken.

The sudden onset of pain implies that a fundamental change has occurred in the coronary circulation. The sudden appearance of heart failure, or of dyspnoea, or characteristic pain is rarely found in any but coronary artery disease, and is obviously due to an accident in some artery in the heart, either in the nature of a partial or total occlusion of a vessel. The symptom need not be too striking. It may be minimal, such as an epigastric distress, a passing heaviness on the chest, or a faint feeling. When such a symptom appears suddenly in a patient who has been perfectly well, but who is in the age group of coronary artery disease, even though the symptom be slight, it should direct our attention to a change in the adequacy of the coronary circulation.

The pain is seldom to the left of the sternum. Occasionally it is under the ensiform in the epigastric region. This location for a pain is the region of greatest confusion. Pain from a stone in the common duct or from a perforating ulcer is sharp and agonizing, may radiate to right shoulder or back, last for hours, frequently recurs, and is never related to effort. It must be remembered that the pain of coronary occlusion is also sharp, oftentimes crushing in severity, may be felt in the epigastrium, but it does not recur, and when present is always associated with serious heart injury. One should suspect as arising below the diaphragm repeated bouts of

sharp epigastric or substernal pain without any cardiac sequelae.

A much more frequent source of confusion with heart disease is the dull ache or stabbing pain under the left breast, or in the left chest. It is a pain often associated with tenderness in this region. It comes and goes for hours or days, unrelated to effort or meals, and occurs as often when resting as when exercising. This is a pain which should turn our attention away from the heart and towards a hypersensitive nervous system. It commonly follows by two to three weeks an upper respiratory infection, but is also frequent in patients with fatigue, emotional strain, or those who have smoked hard and overindulged in alcohol. When it occurs in a patient with organic heart disease, the recognition of this type of pain requires a certain insight into the patient's personality. One must first determine whether the pain is a dull ache or stabbing in character, then if it is located under the left breast. Another question about its relation to exercise will show that it is not induced in this manner. Finally, the history of an upper respiratory infection in the preceding few weeks would almost clinch the diagnosis. The overindulgence in smoking or the existence of an emotional or anxiety state or fear of heart disease also definitely locates the cause of the pain in an oversensitive nervous system and not in the heart itself. It should be emphasized that the presence of such a dull ache or stabbing pain does not mean that the patient has not heart disease or angina. He may have both. In fact, after patients with angina learn of the affliction, they may also develop the dull ache or stab in the left breast because of fear or anxiety. This pain, when present, however, is not related to the heart lesion, but to an oversensitive nervous system. Its presence alone does not require treatment for heart disease and the patients feel better immediately when reassured.

Exceptions—There are two exceptions to what has been said about the dull ache in the left chest which should always be borne in mind: (a) The ache in the left side in patients who have recovered from a coronary occlusion with infarction. Any distress anywhere in the left chest of a patient who has a myocardial scar should be considered seriously, since patients with a cardiac scar do not have classical heart pain. More often the pain is bizarre, obscure, occurring anywhere in the left chest, and always when the heart is tired. It is a signal for further restriction of the patient's activity. (b) Then

there is the uneasiness, epigastric distress, or belching, or faint feeling and fatigue which comes suddenly to an otherwise well person in the age period of coronary occlusion. Symptoms such as these are often the prodromal stage of a coronary occlusion. To be on the alert for these prodromal symptoms may enable us to recognize the occlusion very early. If put to bed, such a patient might heal with a minimum of scar. If, however, the symptoms remain unrecognized and the patient pursues a strenuous mode of life, he might suffer a large infarct or may even die "suddenly". Such symptoms should compel our attention to the heart. It is wise to be alert for the earliest symptoms of coronary occlusion, to suspect it, and use all measures to diagnose it.

TABLE III

PAIN IN THE CHEST

1. Precordial ache—in center of left breast, varying intensity and duration, may radiate down left arm; local tenderness; not caused by effort. (Over-sensitive nervous system).
(a) Stabs of pain—(same explanation).
2. Substernal oppression due to coronary sclerosis.
3. Heart pain in acute pericarditis—if diaphragm or pleural surfaces become affected; aggravated by respiration; may be felt in left shoulder; varies from vague, dull precardial oppression to terrific constant pain requiring morphine.
4. Heart pain of acute rheumatic carditis—a sharp, constant, but bearable pain.
5. Aortic aneurysm—Severe constant ache in regions where pressure of growing aneurysm is applied.
6. Pain of dissecting aneurysm of aorta—excruciating, tearing pain in substernal region, extending into back, arms, and down back to legs; lasts for hours or days.

TABLE IV

HOW TO ESTIMATE THE CONDITION OF A PATIENT SUFFERING FROM ANGINA PECTORIS

1. Obtain a description of the patient's sensations when the pain is present, the position where it arises, in what region it spreads, and where it holds him with the greatest intensity; usually substernal, rarely to left of sternum.
2. Duration of the different attacks, their manner of onset and offset, and such accompanying sensations as a "gripping", sense of collapse, or exhaustion during or after the attack—(when lasting over half an hour suspect coronary occlusion).
3. When did the disagreeable sensation first appear and under what circumstances. Often slight unnoticed attacks of pain or limitation have been felt for years, while in others the attack came on without warning.

4. Circumstances which induce an attack. Do they arise as a response to effort or excitement? Are they worse after a heavy meal? Do they come on while at rest in bed?
5. Inquire about the individual himself; past history of infection; what kind of a life has he led as regards work, worry, food, drink, tobacco.
6. Obtain a thorough knowledge of the patient's response to effort. How much can the patient do in the nature of physical exertion under different circumstances? And what is the greatest amount he can do under the most favorable conditions? Has this amount of exertion steadily contracted in recent months?

C. *Fatigue and Exhaustion*—Patients with heart disease become quickly exhausted, require much rest and sleep, and recover very slowly from fatigue. The patient with heart failure is always tired and never is truly rested, even at rest. The amount of activity of which the patient is capable without fatigue and the time required to recover from fatigue is therefore an important measure of the function of the heart. It takes but a moment to bring this out and the answers will bear greatly upon the evaluation of the patient's heart reserve. How quickly do you get tired? How much rest do you require when tired in order to recover? These are questions that should always be asked. Of course, fatigue is a common symptom in other conditions also, such as chronic infection and nervous exhaustion.

D. *Palpitations*—(Treated later).

E. *Dizziness*—This is not a common symptom in heart disease, but when present can only be attributed to heart disease if it is induced by activity. Occasionally it is an associated symptom of angina pectoris and often is found in coronary occlusion during the acute attack in patients who already suffer from cerebral arteriosclerosis. It is not a major symptom and does not compel attention to the heart, but rather to the cerebral vascular system.

F. *Syncope*—Fainting is not a common symptom in heart disease, occurring in about 1% of organic heart cases. It is a more common complaint in office practice because both doctors and patients feel that in every case of syncope the heart should be ruled out. Syncope can result when heart block occurs in a Stokes-Adams seizure. It is found also in patients who develop a very rapid heart rate during paroxysmal tachycardia or paroxysmal auricular fibrillation. However, the majority of patients with syncope are to be investigated from the standpoint of

the relation of posture to syncope. If the dizziness and faintness occurs on stooping over, or on suddenly standing up from a prone position, one should look for carotid sinus sensitivity. This is a fairly frequent complaint in elderly patients who already have cerebral anemia from sclerosis of the cerebral vessels. Finally, it should not be forgotten that syncope may be the result of hypoglycemia.

3. *What conditions can be recognized by symptoms alone—*

The patient's awareness of his heartbeat is a common sensation, particularly in "heart sensitive" individuals. Palpitation is not usually of great importance as an indication of significant impairment of cardiac function. It is, however, often the first symptom to direct attention to the heart. It may be caused by paroxysmal tachycardia, auricular fibrillation, auricular flutter, or premature contractions. Or it may be a physiological reaction following exercise or emotional stress. We have seen it occur as a prominent feature in the effort syndrome, and during the menopause, and it is commonly associated with fatigue and overindulgence in coffee, tobacco, or alcohol. Since this symptom may be associated with such a variety of conditions, it becomes obvious that a careful history and detailed examination are necessary to determine its significance. Table V describes some of the palpitations of which patients are aware. Often no evidence of these disturbances are present at the time of examination, but their symptoms are so characteristic that they may readily be recognized from the symptoms alone.

a. First is the extrasystole, or ectopic beat. Some feel the heart stops; others, a violent throb; others, a sense of choking and cough; still others, a sense of turning over of the heart. Of course, the ectopic beat itself is actually not experienced. However, this ineffectual beat is followed by a compensatory pause and the oncoming beat is now one in which the heart is overfilled and discharges a large volume into the aorta. This is what the patient feels as a throb, or overturn, or sense of cough, or general flush. Such symptoms are not often associated with serious heart disease. In fact, patients suffering with serious heart disease often do not sense extrasystoles.

b. Paroxysmal tachycardia and fibrillation are always experienced by the patient. The sudden onset, the wavy flutter in the chest, the sense of faintness and weakness, and the sudden termination of

the flutter are common symptoms in these disorders, and such a story is almost diagnostic of the arrhythmia. Often patients will describe the above symptoms, but at the time of examination show no cardiac abnormalities at all. Close questioning will show that the patient has felt the symptoms above and from them a diagnosis of paroxysmal tachycardia may reasonably be made. Furthermore, if the paroxysm lasts for many hours without any associated symptoms of dyspnoea and pain, it gives the physician a clue as to the amount of reserve the heart possesses. A heart that can beat at 180-200 per minute for a long time without signs of failure, must have a good reserve. The opposite is also true; a rapidly beating heart that quickly fails is already seriously impaired. Here again symptoms may give not only a basis for diagnosis of the disease, but also information about the extent of cardiac damage.

c. Often patients will complain of a pounding in the chest, but on questioning will reveal that the rate is not fast, merely very forceful. Such a complaint is frequent in mental anxiety states.

4. *Subclinical rheumatic fever—*

Acute rheumatic fever with its classical picture needs no elaboration from the standpoint of symptomatology. Subclinical rheumatic fever is different. It is obscure, often unrecognized at a time when heart damage is continuing. It requires long rest in bed to protect the heart.

On the other hand to send a child to bed when no rheumatic fever is present is to invalid a healthy child. Much confusion may arise from our inability to differentiate between the non-rheumatic and rheumatic growing pains in children. In order to avoid the dual tragedy of keeping a healthy child in bed for months, while at the same time allowing a sick child to damage his heart by activity, we should learn the difference in symptomatology between rheumatic and non-rheumatic growing pains.

In the following chart (Table VI) M. J. Shapiro has outlined the difference in symptomatology so well and this corresponds so closely with my own experience that I am presenting his differential diagnosis.

It is apparent that joint involvement together with constitutional signs of inflammation serve to distinguish subclinical rheumatic fever, while muscular pains in patients without constitutional signs of inflammatory activity are probably non-rheumatic.

SUMMARY

An analysis has been made of the symptomatology in organic heart disease and in patients complaining of heart disease. The prominent symptoms of dyspnoea, pain, palpitation, dizziness, and syncope have been described and their underlying physiological mechanisms mentioned. Finally, the differential features between subclinical rheumatic growing pains and non-rheumatic growing pains have been presented.

TABLE V

HEART DISEASES THAT ARE DIAGNOSED BY SYMPTOMS ALONE

1.

Extra systole—thump, throb, occasional pain in hypersensitive parts; dizziness, faintness, fluttering, cough.
2.

Paroxysmal tachycardia—sudden onset and offset; disagreeable fluttering or wavy sensation; fullness in neck; faintness, dizziness, syncope, dyspnoea in some, "heartache".

3.

Paroxysmal auricular fibrillation—similar to tachycardia; patient is aware of irregular heart fluttering, pounding, skipping, tumult—more nervous irritation; fear of impending death.
4.

Some cases of coronary sclerosis (angina pectoris)—

A.

The sensation—"Sense of strangling with anxiety", 'heaviness', 'squeezing', 'burning', 'tightness', 'great weight on chest'; usually under upper or middle sternum, but may be to left or right of it.

B.

Radiation—arms, neck and jaws, or to back near left scapula, to epigastrium, and in rare, confusing cases to outlying regions.

C.

Exciting factor—excitement, a full meal, exposure to cold, excessive use of tobacco, dreams, but most often by exercise, more easily induced by combinations of the above.

D.

Duration and frequency—from one-half to several minutes; if longer, suspect coronary occlusion, or indigestion, like gallstones or gastric ulcer—will always be brought on by sufficient exertion.

TABLE VI

SUBCLINICAL RHEUMATIC FEVER (FROM M. J. SHAPIRO)*

DIFFERENCE BETWEEN NON-RHEUMATIC GROWING PAINS AND JOINT PAINS OF SUBACUTE RHEUMATIC FEVER

	NON-RHEUMATIC	SUBACUTE RHEUMATIC
Age at onset:	Early childhood; often continues through adolescence.	Most commonly between 6 and 7; occurs in attacks following upper respiratory infection.
Time of pain:	At end of day and especially during night, often awakening the child several times; pain is gone during morning and day.	On first getting up in A. M. and during the day, especially on motion—often causing a limp. Patient feels better in warm bed.
Location of pain:	Most commonly in muscles of legs and thighs; only rarely in muscles of arms; occasionally involves knees.	In joints themselves of upper and lower extremities.
Other signs of rheumatic activity:	None.	Repeated bouts of joint pains, nose bleeds, skin rash, pallor, fever, etc.
Family history of rheumatic fever:	None.	Common. Joints often have slight increased local heat,
Objective signs in joints:	None.	mild swelling, usually overlooked by patient and parent.
Laboratory findings:	Normal.	Increased sedimentation rate, leucocyte count, and moderate anemia.

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CONSERVATIVE TREATMENT IN FRACTURES OF THE NECK OF THE HUMERUS

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TRAUMATIC SURGERY, like general surgery, is characterized by physical effects of varying severity, hence we speak of *minor injury* and *major injury* to indicate that the initial effect of a given trauma is minor and remains thus, unless through complications it becomes *major*. We recognize also that there is an analogy in general surgery, as for example a non-ruptured appendix by comparison with a ruptured appendix. Likewise our treatment standards for the minor effect differ from our procedures for the major effect. Our prognosis thus differs, in terms of death, disability and deformity—for these 3 D's are the Three Horsemen of Trauma.

There is a category of injuries that I call the "let-them-alone" group, meaning thereby that the formula, time plus rest equals recovery. Too often we forget to invoke the aid of time and rest in our zest to "do something" in the presence of so acute an emergency as accidental injury. The sudden unexpected onset, the dramatic immediate disability, the objective evidences of the incident—all of these tend to unbalance our judgment and cause us to provide a remedy that may harm more than help. We become radical when we should be conservative. We become "leftists" when we should be "rightists." We forget that "they also serve who stand and wait." We fail by undue zeal, and deny our faith in the belief of a judicious leaving alone.

In the leave-them-alone group are found infected wounds and tendon injuries. To interfere with the former too early is to spread the infection. In the latter, unless there is an attempt to suture within the first six hours post-trauma, it is better to postpone the necessary surgery until the associated wound has been healed a month or more. Conservative treatment should not be an after thought following unsuccessful radical treatment, but instead we should embark on the conservative route from the onset.

Next to the treatment of infected wounds, the

conservative management of fractures is probably most important. There is a group of broken bones in which the formula time plus rest equals recovery, and broadly stated this applies to all fractures of the shaft and joints in which there is minimum displacement of the fragments. Function is the end in view in our planning, and form is of secondary importance. How will it act speaks louder than how will it look.

The conservative approach aptly applies to our chosen topic, for as we all know there is much confusion regarding the management of this fracture. Too often massive splintage is applied or the patient is put to bed in traction, or more grievous, open operation is attempted. We should not base our treatment merely on the diagnosis, but rather on the effects disclosed by the diagnosis. There is little tendency toward redisplacement in the category under discussion—if we let it alone.

If the trauma producing the fracture has not separated the fragments, it is important for us to realize that any additional trauma from meddling will do that very thing. Hence a non-interference policy is advocated and if we are prudent in the selection of cases our casualty rate will be minimized.

There is a fairly uniform fracture pattern when the neck of the humerus is broken. As in all fractures, there are two basic types in this area depending upon the extent of the displacement of the main fragments. In Type I the fragments are displaced to such an extent that their ends are not in contact. In Type II the fragments may be somewhat displaced, but they are contacting. It is to this latter type that I direct attention, and it may be designated as the impacted, the contacting, the non-displaced, the Type II, or any other denominator you choose to apply to this traumapathy. The chief object of this inquiry seeks to show that the main factor in recovery is preservation of the concavo-convex relationship of the head-socket axis, rather than any realignment of the shaft-neck axis. A secondary object is to show that ambulatory treatment with immediate motion and minimal apparatus will aid repair of the fracture and prevent the peri-articular

adhesions that so often interfere with the maximal function, thus preventing the so-called "frozen shoulder" due to fibrosis. Naturally in any discussion of this fracture zone, we think of the analagous fracture of the neck of the femur, and surmise as to why in the one zone healing is so predictable, and in the other so unpredictable. The humerus is the femur in diminutive; the scapula is the pelvis in miniature. In the one zone automatic respiratory motion activates 18-20 times a minute; in the other, voluntary motion must be substituted. The shoulder girdle vascular supply exceeds that of the hip girdle; but in nearly all other respects, the architecture is almost identical although less massive.

All fractures in this area articulated to the mobile chest wall seem to heal rapidly despite gross deformity, but just as soon as a fracture of the humerus involves the area below the surgical neck we pass abruptly into a zone of non-union and difficult management. The clinical truism is that all joint fractures heal well except those affecting the hip joint. The surgical neck of the humerus is broken usually by a fall directly over the joint and less often by a fall transmitted from the outstretched arm, the elbow or the hand. A twist or rotation is rarely responsible as is so often the case in fractures of the neck of the femur.

The humeral neck line of fracture usually appears in three patterns as follows:

1. *The transverse*, in which the epiphyseal line area is traversed with fair regularity.
2. *The oblique*, in which there is more or less vertical cleavage also.
3. *The comminuted*, in which the lines of fracture are numerous, the tuberosities being involved, especially the external.

This division is more or less arbitrary, but it is clinically adaptable and serves as a basis for description in the vast majority of cases.

The pathological anatomy is like that of any other joint fracture; and, with the bony laceration as the basis, we add myo-teno-synovitis, vascular rupture and possible neural damage. These last named together are termed traumatic arthritis and periarthritis. Because of a lax capsule attached to the anatomical neck, and an accessory of the capsule called Flood's ligament running from the inner margin of the glenoid to the lesser tuberosity, there is lacking in these fractures any marked displacement.

The *symptoms* of this non-displaced group often resemble a contusion-sprain inasmuch as bony deformity is generally absent, and there is usually little demonstrable false motion or crepitus. Local pain however, can frequently be elicited by pressure, abduction, or rotation. However, the search for corroboration should not be pursued if x-ray examination is possible, because incautious manipulation may displace the fragments. In older patients, shoulder injury, like hip injury, should make us suspect fracture.

Diagnosis as between a non-displaced neck fracture and a contusion-sprain, or a self-reduced dislocation, is difficult without x-ray corroboration. The extent of disability should theoretically place us on guard, especially if the violence has been adequate. However, the loss of function may be slight if the fragments are well notched, as they are so frequently.

Treatment is designed to retain the position, and at the same time prevent crippling arthritis or periarthritis. At once the question arises as to what steps, if any, should be undertaken if the fragments are not wholly contacted? Should we manipulate? Should we apply traction? If so, should we adopt the classic posture of abducting the area to a right angle or less? In what percentage of cases will abduction fail and adduction suffice?

Should the fragments not be wholly contacted the question of manipulation, traction, abduction or adduction must be settled.

My contention is that the average case requires no manipulation whatever, inasmuch as the main object of treatment is to retain the convex head in the concave glenoid and thus preserve the rotatory function of this articulation. Since an end-to-end contact of 50-60 per cent is apparently adequate for our purpose, this fracture falls into the leave-them-alone group. In patients under 17 years of age, surgical neck of the humerus fracture has as a replica epiphyseal separation and here the leave-them-alone dictum has a more limited application. Growth disturbance fortunately is rarely compromised by malalignment at the shoulder joint.

The details of treatment are relatively simple, and my practice is to embrace the summit of the joint in four three-inch straps of adhesive, two or three run half-way down the arm from the neck-shoulder line, and two are placed transversely from the mid-clavicle level to the mid-scapular level. The arm is carried at the side, and the forearm rests in a sling.

An alternative method is to apply a modified gauze spica which acts as a pressure pad over the joint and also slings the forearm at a comfortable level. In selected cases in coöperative patients a sling is all that is necessary. However, in every case the patient is cautioned to fasten the sleeve of the night clothing to the waist to prevent the arm-over-the head position assumed by so many sleepers. It appears unnecessary to aspirate the shoulder joint, and I very much doubt if that procedure would aid in recovery.

Motion begins at once, and the patient from the outset is told to shrug the shoulder in an up and down manner. The application of heat to the joint will prove agreeable, and hence we advise the use of a heat lamp or the rays from an ordinary 100 watt bulb, these agencies to be used as desired.

For pain thus unrelieved, any chosen sedative may be used. The use of massage is optional, as is the employment of any other physiotherapeutic device. Ecchymosis, even if extensive, is never combated. Blebs are exceedingly rare in any upper extremity fracture except as an evidence of grossly impaired circulation.

After this shrugging motion becomes painless, the patient is taught to perform what I call "compass exercises." These are used by me in many fractured zones. A weight of a few pounds is held in the hand, and with the elbow straight and the trunk bent, this weight is swung forward, (denoted as North) then backward (denoted as South), then to the right (denoted as East) and then to the left (denoted as West). The East and West pendulum actions are at first purposely limited, as indeed they will be because of pain. The value of this type of "compass exercises" is self-evident, and it can be practiced many times daily if desired. After 10-14 days a few trials of abduction can be made, such for example, as resting the elbow on the raised arm of a chair. If this is relatively painless, the patient may be encouraged to lay the flat of the hand against to waist-line and gradually climb up the chest wall. Thereafter many devices may be advised such as climbing the wall, resting the arm on the top of a high backed chair, or on a table, a bureau or mantel piece. Finally the opposite hand is passed over the head and grasps the hand of the injured side in an attempt to make it rest on the top of the head. When this is possible, the physiologic limit of abduction, namely a right angle, will have been regained.

Purposely, rotatory motions are not enforced

early. However, when the other activities are painlessly performed, the patient is encouraged to try adduction and external rotation by placing the hand palm down across the chest. Likewise he is taught to bring the arm backward in the palm up position to promote internal rotation, although this last is often actually an element in abduction. These activities should not produce reaction as denoted by prolonged pain, swelling or heat; if these appear, their repetition is to be avoided. Union progresses in two stages, as in all fractures. What I call semi-solid or lead pipe union is apparent within six weeks. At first, the fracture line may appear irregular by x-ray in the group in which there has been malalignment from the outset; but this disappears very quickly owing to the gliding action of the superimposed musculature.

In passing, let it be stated that even if the fragments or tuberosities appear at first to be detached, they eventually are blended into the mosaic that recasts and welds into nearly normal contour.

Nerve damage, as intimated is exceedingly rare; the circumflex or the ulnar occasionally are involved. Vascular damage is also exceptional, and unless constricting dressings are applied, edema is usually transient. The ecchymosis may persist for weeks and it often discolors to the elbow level and across the chest wall; however it is harmless unless molested.

In some patients the final range of motion may be difficult to attain, and if so, much progress will follow carefully conducted closed manipulation under intravenous (Evipal, or Pentothal-Sodium) or gas-oxygen anesthesia.

This then is an example of the conservative and simple as opposed to the radical and complex management. It avoids the bed traction methods, and the aeroplane splintage in plaster or metal. Incidentally, a number of displaced surgical neck fractures reduced early can be satisfactorily managed along this same route, because once the fragments are in contact they tend to remain so.

CONCLUSIONS

1. There is a group of injuries in which the let-them-alone policy is better than the do-something policy. The conservative method achieves; the radical fails.
2. This fracture follows a fairly regular pattern irrespective of the actuating violence.

(Concluded on page 312)

SURVEY OF THE ANESTHESIA SERVICE AT GRASSLANDS HOSPITAL 1938 TO 1940

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1939 to date

Doctor Bishop's paper presented at the meeting of the Section on Anesthesia of the Connecticut State Medical Society in Hartford was purposely arranged to follow one by Doctor Meyer Saklad of Providence, Rhode Island, dealing with factors governing proper choice of anesthetic agents and methods. This paper indicates results that may be achieved when a competent anesthetist has an opportunity to organize a department and introduce and wisely apply agents and methods now available.
(The Editor.)

THE POSITION of Divisional Head in Anesthesiology and Gas Therapy was created at Grasslands Hospital in 1938. The incumbent took up the duties of such on July 1, 1938. This report on the activities of the Anesthesia Service will cover the period from that date until April 1, 1940. It is intended that this survey will present in statistical fashion the number of anesthetic administrations performed, the various agents and methods used, together with reference to data on gas therapy and procedures allied to anesthesia. The department was to function with the association of a resident on anesthesia and the services of one interne. The number of administrations by each of the department members is given in Table 1.

The frequency with which the various routes for anesthetic administrations were used is shown in Table 1. Inhalation accounted for 62% of all administrations. The next most commonly used anesthetic was some type of regional method, followed in order of frequency, by spinal, intravenous and rectal. Very seldom did the occasion for rectal anesthesia arise.

Ether was used in a little better than half of the group who received an inhalant agent. Cyclopropane was employed in 28%. It has been the agent which has most commonly been used for thoracic

surgery, upper abdominal surgery and major gynecologic procedures. Cyclopropane, in high concentrations and with respirations controlled according to the technique of Guedel, has been utilized in a small group of patients. In poor risk individuals, who have undergone abdominal operations, cyclopropane has often been fortified with abdominal block. Helium as a diluent with cyclopropane and oxygen mixtures has been available for the past year. Nitrous oxide was used less extensively than ether or cyclopropane. However, there are many procedures which can be performed to advantage under nitrous oxide, alone or in combinations with other anesthetics. Nitrous oxide, combined with repeated fractional doses of morphine, has been preferred to other inhalation agents for thyroid surgery. Vinyl ether, or vinethene, had been in use for a period of three months only.

Forty-three per cent of the inhalation anesthetics were performed by endotracheal anesthesia. Those on the staff who were learning the technique of intubation were given ample opportunity. The frequency and severity of laryngeal and tracheal complications following the passage of an endotracheal tube are probably proportional to the trauma inflicted during the performance of intubation. Cocainization of the pharynx and larynx by the instillation of 2 to 3 c.c. of 5% cocaine through the pharyngeal airway prior to intubation facilitates this procedure. Endotracheal anesthesia in addition to its other benefits affords a means of tracheal and bronchial aspiration at the termination of the operation. Such aspirations are routinely carried out in an effort to reduce the possibility of pulmonary complications.

For procedures about the head and neck a method of ether administration has been utilized which has been designated as the Flagg Method. It consists of an endotracheal tube inserted through the nose to which an ether can be opened by multiple holes is attached. Such a simple and convenient means for ether administration has been used in 25% of the inhalation cases. It has been used routinely for ton-

Read at a Joint Session of the Section on Anesthesiology of the Connecticut State Medical Society and the American Society of Anesthetists, Inc., in Hartford, May 22, 1940.

TABLE 1
SUMMARY OF ANESTHETICS

July 1, 1938 to April 1, 1940

Total Number	2682
Inhalation	1673 — 62%
Regional	351 — 13%
Spinal	346 — 13%
Intravenous	288 — 11%
Rectal	24 — 1%
Administrator:	
Anesthetist	1077
Residents	922
Interns	683
<i>Inhalation</i>	1673
Agents: Ether	926 — 55%
Cyclopropane	473 — 28%
Nitrous Oxide	259 — 16%
Vinyl Ether	15 — 1%
Methods: Endotracheal	(723) — (43%)
Flagg Method	(424) — (25%)
<i>Spinal</i>	346
Agent: Pontocaine—Procaine	
<i>Intravenous</i>	288
Agent: Pentothal Sodium	
<i>Rectal</i>	24
Agent: Tribromethanol	
<i>Dental Anesthetics</i>	75
Nitrous Oxide	29
Ether-Endotracheal	22
Pentothal Sodium	19
Vinyl Ether	5
<i>Obstetrical Anesthetics</i>	206
Nitrous Oxide	139
Nitrous Oxide—Ether	51
Ether	9
Cyclopropane	4
Sacral Block	3
<i>Tonsillectomy Anesthetics</i>	546
Ether—Endotracheal	326

sillectomy, mastoidectomy, and in many instances for procedures within the mouth and upon the eye.

Spinal anesthesia has been usually restricted to procedures of the lower abdomen and extremities. Hernia of the lower abdomen, appendectomy in individuals with muscular abdominal wall, orthopedic procedures upon the lower extremities and certain urologic operations fall into this group. A combination of pontocaine and procaine solutions together with ephedrine has been used in all cases. The dosage of pontocaine has not exceeded 15 mg.

Intravenous anesthesia with a 2½% solution of pentothal sodium has been used in a group of cases where minor short procedures are to be carried out.

No attempt has been made to apply its use alone to major procedures except in combination with a regional method.

The small group of dental anesthetics has been fairly well distributed between several agents by inhalation and intravenous anesthesia. Nitrous oxide has been used in the majority of instances to provide obstetrical anesthesia. Endotracheal anesthesia for tonsillectomy has become a routine procedure for the past year and a half. Intubation is carried out on all ages. Pharyngeal insufflation of ether has been discarded without regret.

One of the most satisfactory methods of anesthesia production at the disposal of the anesthetist is the employment of a regional procedure. Table 2 shows that a regional procedure has been utilized in 351

TABLE 2
REGIONAL ANESTHETICS

Total	351
Abdominal Block	100
Sacral Block	85
Cervical Block	26
Brachial Block	19
Digital Block	19
Circumcision Block	18
Intercostal Block	5
Wrist Block	3
Orbital Block	2
Infraorbital Block	1
Mandibular Block	1
Maxillary Block	1
Mental Block	1
Epidural Block	1
Ankle Block	1
Field Blocks	52
Skin Graft	19
Sternal Biopsy	6
Lipoma	5
Breast Tumor	4
Inguinal Gland	4
Cervical Gland	3
Vein Ligation	3
Ganglion	3
Fibroma	2
Muscle Biopsy	1
Laminectomy	1
Bone Graft	1
<i>Infiltration</i>	16
Tonsillectomy	8
Vasectomy	4
Removal of bone plate	2
Radon Seeds Insertion	1
Excision of Scar	1
Agents: Procaine—Cobefrin	333
Intracaine	18

instances. Procaine has been used in the majority of these cases. A small group has been performed with intracaine. Abdominal block has been used for a variety of procedures such as hernia, colostomy, suprapubic cystotomy and in combination with inhalation for upper abdominal surgery. All operations upon the rectal area, except for drainage cases, have been performed under sacral block. It has in addition been used for many urologic procedures: perineal and transurethral prostatectomy and operation upon the genitalia. Cervical block has been carried out mainly for thyroidectomy. The majority of orthopedic operations upon the upper extremity have been done under brachial block. Simple field block has been found to have a wide variety of application. In a smaller group infiltration has been utilized.

Oxygen therapy, instituted during the course of

TABLE 3

SUMMARY OF OXYGEN THERAPY

Total Administrations	396
<i>Method of Administration:</i>	
Catheter	293
Tent	60
B. L. B. Mask	25
Incubator	9
Oxyflow	5
Face Mask	4
<i>Diagnoses of Patients Receiving Oxygen:</i>	
Heart Disease	123
Post-Operative	113
Pneumonia	82
Miscellaneous	78
<i>100% Oxygen by B. L. B. Mask</i>	

Diagnoses

*Abdominal distention	5
Heart Disease	5
Migraine	4
*Hiccup	2
*Headache (Encephalography)	2
Gangrene of Leg (B. Welchii)	1
Spontaneous Pneumothorax	1
*Pulmonary Atelectasis	1
Pulmonary Edema	1
Bronchial Asthma	1
Carcinoma of Lung	1
Poliomyelitis	1
(*Post-Operative States—9)	

SUMMARY OF HELIUM THERAPY

Total Administrations	10
<i>Method of Administration:</i>	
B. L. B. Mask	10
<i>Diagnosis:</i>	
Bronchial Asthma	10

spinal or intravenous anesthesia, has proved its merit in many instances. Morphine sulphate administered intravenously has been used quite frequently in conjunction with various anesthetics and in the control of emergence delirium. The anesthesia department has taken an active interest in the problem of post-operative pulmonary complications and has aided in their early detection and treatment.

Oxygen therapy was administered to a total of 396 patients (Table 3). The most efficient and satisfactory method of administration proved to be oropharyngeal insufflation by catheter. The need for oxygen in post-operative states is indicated by the proportionally large number of patients who received it at this time. Following major procedures its use is becoming as common as the venoclysis. Helium therapy on the wards has been available during the past year. Ten patients with bronchial asthma were given helium-oxygen mixtures. In some the relief was striking.

High oxygen concentrations have been administered to a group of 25 patients using the B. L. B. mask. Post-operative states comprised 9 in this group. Its effect in paralytic ileus has been difficult to evaluate because other types of therapy are usually in progress at the same time. One patient with migraine is readmitted to the hospital for this therapy whenever an attack develops. The patient with poliomyelitis had intercostal paralysis. It appeared that the B. L. B. mask was of particular advantage in this type of case.

Occasionally the anesthesia department is given a sedation problem to treat when ordinary means have failed (Table 4). Most commonly a moderately long acting barbiturate was used intravenously in these instances. The patients with epilepsy were given tribromethanol; the patient with tetanus was given ether.

Any opportunity to carry out a diagnostic procedure utilizing anesthetic methods was taken advantage of. Therapeutic nerve blocks were carried out on three patients. One of these was given alcohol intraspinaly by the technique of Dogliotti. Marked improvement followed the administration of cyclopropane to a patient with status asthmaticus. Other therapeutic measures had failed in this patient and she had become comatose and deeply cyanotic.

Recently there has been interest in attempting to prevent the occurrence of shock in those patients who are to undergo long serious operations by the administration of adrenal cortex hormone pre- and

post-operatively. A group of 16 patients have been placed on a routine which consists of daily administrations of desoxycorticosterone acetate together with high vitamin, high caloric, high protein diet with abundant fluid and salt intake, for a period of 5 days prior to operation and for 1 to 2 weeks following operation. Such a regime has been advocated by Perla. It is hoped that by this preparation the patient will be better fitted to withstand the strain of operation and anesthesia. No conclusion can be derived from the possible value of instituting this therapy in so small a group of patients.

Conclusion. An attempt has been made to meet the anesthetic needs of Grasslands Hospital by diversification in the application of anesthetic methods. To bear out this contention a statistical survey over a 21 month period has been presented.

TABLE 4

PROCEDURES ALLIED TO ANESTHESIA

Treatment of Sedation Problems (7)

Diagnoses

Status Epilepticus	2
Skull Fracture	2
Delirium Tremens	1
Tetanus	1
Mania	1

Agents Used

Sodium Amytal	4
Tribromethanol	2
Ether	1

Diagnostic Procedure (5)

Bronchiogram	1
Spinogram	1
Hypertension Test	1
Diagnostic Spinal	1
Paravertebral Block	1

Therapeutic Nerve Blocks (3)

Sciatic pain	2
Intrathecal Alcohol	1

Cyclopropane as Therapy

Bronchial Asthma	1
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Pre and Post Operative Therapy

Directed Toward the

Prevention of Surgical Shock
by the use of

Adrenal Cortex Hormones

Number of Patients Receiving Therapy	16
Number of Operations	13

The cost of taking a man who has tuberculosis into military service is around \$10,000 per man. Ramsey Spellman, M.D.

Neuro-Psychiatric Institute Acquires Noted Jelliffe Library

Acquisition of a 15,000 volume medical library described by bibliophiles as the most complete of its kind in the world, was announced recently by Doctor C. Charles Burlingame, Psychiatrist-in-Chief of the Neuro-Psychiatric Institute.

The library, representing a lifetime of collecting by Doctor Smith Ely Jelliffe of New York, nationally known psychiatrist and Editor of the Journal of Nervous and Mental Diseases and the Psychoanalytic Review, is to be transferred to the Institute "to assure a permanent home for it under conditions which would be of satisfying benefit to future generations of psychiatrists and neurologists" according to Doctor Jelliffe.

In making this announcement Doctor Burlingame also made public the report on the Jelliffe Library by Mr. Morris C. Leikind of the Library of Congress. "The Jelliffe collection in neurology and psychiatry" states Leikind's report, "is probably the largest and most complete private library in its field in the country. In addition to the 15,000 volumes it contains 25,000 reprints and covers every aspect of the fields in which Doctor Jelliffe is regarded as a master. The psychoanalytic section of the library is one of the best collections of its type to be found anywhere. The value of this collection as an instrument of research lies in its totality. It not only represents a lifetime of single minded collecting, but a lifetime of research and contributions to knowledge. The breakup of the collection would therefore destroy the very thing which Doctor Jelliffe tried to create—that is, its unity."

Included in the collection are some rare historical works dating back to the 15th century as well as practically all important psychiatric monographs from the time of Pinel and Esquirol, pioneers in the enlightened treatment of the mentally ill, down to the present day. Reprints include contributions from practically every civilized country and because of the unique method of binding, used by Doctor Jelliffe, these reprints are of inestimable value to research workers. Doctor Jelliffe has combined all reprints concerning a specific subject or disease entity in one group so that it is possible for the research worker to trace the development of treatment and historical aspects of that disease in a matter of hours, avoiding weeks of research through card files and by reference to many different volumes.

A CASE OF WANDERING SPLEEN WITH TORSION OF THE PEDICLE SIMULATING A PELVIC TUMOR, WITH A REVIEW OF LITERATURE

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WANDERING SPLEEN with twisted pedicle is a condition rarely encountered and still more rarely diagnosed prior to operation. I therefore feel justified in adding one more case report to the few so far described in the literature. The possibility of this splenic condition has been recognized for some time. Piersol¹ in 1908 referred to a movable spleen (dislocated, floating or wandering spleen) and described the condition and its complications accurately. A search of the literature has revealed 98 cases of wandering spleen with twisted pedicle.

GENERAL CONDITIONS

Age and Sex—Wandering spleen with twisted pedicle usually occurs in females. Of 93 cases in which the sex was stated, only five were in males. Twelve were observed before the age of 20, the youngest being six years of age. Fifty-six occurred between the ages of 40 and 80.

Anatomy—The spleen is a lymphatic organ of mesodermal origin, weighing about 160 grams in the adult and measuring 12 by 7 by 4 centimeters. Together with its pedicle it is often said to resemble a mushroom on its stalk. The spleen is situated in the left hypochondrium behind the stomach. Its largest surface is convex and lies against the diaphragm. A plano-concave renal surface, a concave gastric surface and a basal surface are present. The spleen is covered in front by the stomach, the cardiac end of which may completely overlap it when the stomach is distended. Posteriorly, the spleen is covered at its lowest part by the diaphragm and the tenth and eleventh ribs and their overlying muscles. Inferiorly, the spleen lies in contact with the upper end part of the outer edge of the left kidney and externally with the splenic flexure of the colon. The upper part of the splenic surface may sometimes lie in contact with the left lobe of the liver.

The splenic artery reaches the spleen through a peritoneal fold, either the lieno-renal or the lieno-

phrenic fold. The vessels for the stomach leave the artery before it enters the spleen by the fold known as the gastro-splenic omentum. Besides these peritoneal folds or ligaments an inconstant suspensory ligament and a shelf-like phreno-colic ligament are recognized. The stalk or pedicle is supported in position by the lieno-renal and gastro-splenic ligaments and below by the phreno-colic ligament. The blood vessels, lymphatics and nerves which supply the spleen are all enclosed in the pedicle.

Pathology—A wandering spleen is associated with an elongation or stretching of the phreno-splenic ligament, causing the spleen to fall forward being sustained only by the gastro-splenic ligament and vessels which frequently give way causing a gastric prolapse with gastro-intestinal disturbance and possibly, if the vessels are twisted and obliterated, a fatal case of peritonitis. (Piersol¹).

Torsion may range from a half turn to six complete turns. Splenomegaly is not considered a factor in elongation of the pedicle for wandering spleen with twisted pedicle has not been reported in cases of Banti's or Gaucher's Disease, leukemia or hemolytic jaundice. The largest pedicle described measured 25 cm.

Symptoms and Physical Signs—A wandering spleen usually remains symptomless unless the pedicle undergoes torsion. When the onset is gradual, colic of mild type due to partial twists of the pedicle occur, as far as we can determine,—often accompanied by digestive and circulatory disturbances due to pressure on other organs or to reflex nerve impulses. When the onset is more acute, colicky pain, nausea, vomiting, elevation of the pulse and temperature frequently occur. A blood count frequently shows an increased leucocyte count. Besides complete torsion of the pedicle, another infrequent complication sometimes encountered is adhesions of the bowel to the pedicle and often bowel compression from the same cause. Naturally these complications will give rise to gastro-intestinal symptoms.

Differential Diagnosis—Since the spleen may migrate to any part of the peritoneal cavity, the cor-

rect diagnosis is rarely made before operation. The condition is often confused with acute appendicitis with peritonitis, abdominal tumor, or ovarian cyst with a twisted pedicle. An important diagnostic point is that a wandering spleen is replaced into the upper part of the peritoneal cavity when the patient is placed in the Trendelenberg position.

Treatment—Treatment for wandering spleen with twisted pedicle is splenectomy. This treatment will appear rational when it is remembered that the spleen has undergone a certain amount of degeneration owing to damage to its blood supply. Any attempt at conservative measures such as splenopexy will result in failure by recurrence. The loss to the body of the function of the spleen has been offered as an argument in favor of conservative treatment, but other organs and tissues of a similar histological nature will compensate for the loss of the spleen's hematopoietic function.

Prognosis—The prognosis in cases operated upon in time is excellent except during pregnancy or the puerperium, when the mortality rate is 41.7 per cent.

REVIEW OF THE LITERATURE

Kumaris² described a case of dermoid cyst in a wandering spleen, the patient being a woman of 40. The case simulated an ovarian cyst. Total extirpation could not be carried out so partial removal was performed with a good result except for a post-operative fistula.

Brossman³ described a wandering spleen with twisted pedicle in a woman of 45 who was three months' pregnant. Symptoms continued throughout pregnancy and became violent shortly after delivery. Diagnosis was uncertain preoperatively. Splenectomy resulted in full recovery.

Sen⁴ reported a case of an enlarged wandering spleen with twisted pedicle in a Hindu woman of 28, the spleen having been mistaken for an ovarian tumor. Splenectomy brought about complete recovery.

Elder⁵ described a case of wandering spleen with an enlarged but untwisted pedicle. Vague digestive symptoms had been present. Splenectomy was followed by full recovery.

Abel⁶ reviewed 95 cases of wandering spleen published in the literature and added two of his own.

Percy⁷ presented a case of a ten year old boy with a wandering spleen resulting in attacks of nausea, occasional vomiting and cramplike abdominal pain.

Operation revealed a wandering spleen with a twisted pedicle. Full recovery followed splenectomy.

Motley⁸ reported a case of wandering spleen and torsion of the pedicle in a boy of eight. Acute symptoms occurred at intervals since the age of two. Splenectomy resulted in full recovery.

Truesdale and Freedman⁹ described a case of wandering spleen with twisted pedicle in a girl of eight with colicky pains, a mass in the right lower quadrant, nausea and vomiting. Operation revealed a much enlarged spleen with engorgement, infarction and considerable impairment of the circulation following torsion of the pedicle. Convalescence was uneventful until a month after operation when a second operation had to be performed on account of partial intestinal obstruction due to a dense fibrous band.

CASE REPORT

C. N., Female, aged 14, admitted to the gynecological service of the Hospital for Joint Diseases April 5th, 1939.

*Service of Doctor A. J. Rongy.

CHIEF COMPLAINT

Abdominal pains since one day before admission, occurring immediately after breakfast. Pains became worse during the day and are constant in type. Vomited six times during the day. No diarrhea. No hematuria.

PHYSICAL EXAMINATION

Breasts—Virginal type. No secretion. No masses.

Heart—Not enlarged. Sounds are clear. Systolic apical murmur is present. P₂ is louder than A₂.

Abdomen—There is a firm, hard, nonmovable intraperitoneal mass in the lower abdomen. It extends upward as far as the umbilicus. There is lower abdominal distention without tenderness or rigidity.

Rectal Examination—Rectal examination reveals a semi-solid tumor mass extending from the posterior culdesac up to a point two inches below the umbilicus. The mass is apparently lying in the left culdesac, is movable and can be shifted over to the mid-pelvic line. The mass is irregular in outline. No evidence of pregnancy is present.

Provisional Diagnosis—

- (1) Uterine fibroid.
- (2) Solid ovarian tumor.

Ascheim-Zondek test was reported positive on May 6th, but upon being repeated several times, the subsequent tests were all negative.

Operation was performed on May 16th, 1939. Midline incision, 4 inches in length, extending upward from the symphysis. With the patient in the Trendelenberg position, the pelvic mass could no longer be palpated, and upon opening the abdomen, no tumor could be found in the pelvis. In the left upper quadrant, a huge tumor was felt. This mass was movable and when delivered into the pelvis and through the incision, it was recognized as the spleen which was

twisted upon its pedicle so that the anterior notch faced posteriorly. It was about three times the normal size, deep blue, and markedly congested. The liver and gall bladder were palpated and felt to be normal.

The spleen was removed after doubly ligating the pedicle. About 300 c.c. of blood escaped from the spleen following its removal, when the organ returned to its normal size.

Blood transfusion of 500 c.c. of citrated blood was performed.

Progress notes—Patient made an uneventful recovery and was discharged upon the thirteenth day.

LABORATORY REPORTS

Pathological Examination of Specimen—Gross examination shows the spleen to measure approximately 20 cm. in length. Capsule is grayish red in color and is somewhat thickened. Spleen is rather rubbery in consistency. Section shows nothing remarkable except for conspicuous sinus hyperplasia. This finding indicates venous stasis and could very well be the result of dragging or torsion of the splenic vein near its pedicle.

May 21st, 1939. Urine negative. Wasserman negative.

Blood Counts—

DATE	H.B. (GMS.)	R.B.C.	W.B.C.	SEG- MENTED	NON-SEG- MENTED	EOSIN- OPHILES	BASO- PHILES	LYMPHO- CYTES
May 5th,	12	4,480,000	10,600	73	4	1	1	21
May 12th,	14	4,864,000	18,600	83	4			12
May 19th,	13.6	4,320,000	10,300	62	13			21
May 23rd,	13.2	4,640,000	9,900	71	2	2		25
June 3rd,	11	4,592,000	9,800	6	3	2		31

1 myelocyte

DATE	COAGU- LATION TIME	BLEEDING TIME	PLATE- LETS	SEDIMEN- TATION (MM. IN 45 MINUTES)
May 17th,	2	2	150,000–250,000	15 mm.
	5	2	96,000	12 mm.
May 18th,	5	3	136,000	13 mm.
May 19th,	5	2	128,000	10 mm.
May 23rd,	4	3	176,000	12 mm.
May 24th,	5	3	274,000	13 mm.
June 3rd,	3	2	96,000	12 mm.
June 25th	4	3	288,000	13 mm.

X-ray Report—(May 6th) There is an ill-defined soft tissue density in the left side extending from the level of the transverse process of the third lumbar vertebra down to the pelvic inlet. Both kidneys are visualized and appear to be normal in size, shape and position.

SUMMARY

(1) Wandering spleen with twisted pedicle is a condition rarely encountered and rarely diagnosed preoperatively.

(2) The anatomy of the spleen and the pathology of torsion of the pedicle, the resulting symp-

toms and physical signs as well as the differential diagnosis have been discussed.

(3) A case of wandering spleen with twisted pedicle has been presented adding to the relatively small number of cases thus far reported in the literature.

(4) Bearing in mind the possibility of wandering spleen, the surgeon will be able to make the correct diagnosis more frequently.

(5) Splenectomy is recommended as the only safe and sure method of complete relief of symptoms and offers an excellent prognosis excepting when it occurs as a complication of pregnancy.

Editor's Note: *W. Lowndes Peple, M.D., Richmond, in the Virginia Medical Monthly, April, 1940, reports a case of wandering spleen with torsion of pedicle simulating a pelvic tumor. This case was in a 74 year old woman. The pre-operative diagnosis was that of an ovarian cyst with twisted pedicle or a walled off appendiceal abscess. On the 10th post-operative day after removal of the spleen the wound opened spontaneously without evidence of infection or hemorrhage present. Death followed on the 12th post-operative day. The pathological report showed infarction of the spleen. This writer reports that 103 cases of pelvic spleen with twisted pedicle had been reported prior to his case.*

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THE APPENDICITIS SYNDROME DUE TO FOOD ALLERGY

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IN THE PAST, the respiratory tract, with manifestations of hay fever and asthma, and the skin have been considered the chief shock organs. Atopy of the gastro-intestinal tract has been given more consideration by the clinician in recent years. Sensitivity producing the syndrome of appendicitis must now occupy the attention of the surgeon.

LITERATURE

Lintz,³ in reporting 300 cases of asthma, found a number of patients suffering with appendicitis, allergic in origin. In these cases there was a positive family history of appendicitis which he considered significant. McIntosh,⁴ in 1930, studied the contents of the lumen as well as the walls of 310 appendices, and was able to differentiate the allergic from the infected appendix. The former was characterized by (1) eosinophilic infiltrations of the wall, (2) excessive amount of mucus in the lumen and (3) Charcot-Leydin like crystals. In 44 of these cases, eighty per cent had a blood eosinophilia ranging up to eight per cent; 84% had a history of long standing pain; 80% presented a temperature above 99 F. L. P. Gay⁵ reported two cases of abdominal pain undoubtedly due to food sensitivity with the symptomatology controlled by restricting the offending foods from the diet.

Friedenwald-Morrison, in 1934, reported a case of right lower quadrant pain present for 34 years in a man 55 years of age. This patient was symptom free following the elimination from his diet of chicken, tomatoes, turnips and cabbages. Rowe,² besides reporting two cases of abdominal pain due to food allergy, studied 107 cases of suspected allergic appendicitis in which operation was resorted to, with no relief resulting in most of these cases.

The following case is presented as another concrete example of the etiological relationship of the appendicitis syndrome and food allergy.

CASE REPORT

E. L., a male, age 8, attending school, was seen by Dr. H. Sherwood complaining of pain in the lower abdomen

which later radiated to the right side. Physical examination revealed distinct tenderness in the right lower quadrant over McBurney's point, and some spasticity. The abdomen was otherwise soft and negative. The temperature, pulse and respiration at the initial examination were normal. Also present was a skin eruption, eczematoïd in character. Because of the skin lesion associated with the abdominal complaint, the child was treated expectantly and when the abdominal signs disappeared in 24 hours, he was referred for an allergic investigation.

Family History. The maternal grandmother who had been treated for frequent attacks of angina pectoris was found to be sensitive to pyramidon. The mother, during the pregnancy with the patient, was seized with pain in the right lower quadrant, vomiting and urticaria. At the time a diagnosis of appendicitis was made, but due to the pregnancy and the skin eruption, she was treated conservatively, and her symptoms disappeared. There has been no recurrence since.

Past History. Medical: Measles, chicken pox, and occasional respiratory infections. Surgical: Negative. Systems: No significant complaints with the exception of the skin. It has been noted over a period of two years that the patient was bothered with a dermatitis in the spring and fall. A diagnosis of poison ivy dermatitis was made. He was given two doses of almond extract of rhus toxicodendrum, and the skin lesion promptly disappeared.

Present Illness and Progress. During one of his early visits for skin testing the mother complained that he had had another attack of right-sided pain early in the morning. Examination revealed marked tenderness in the right lower quadrant and definite spasticity. He was referred for a blood count and resulting in the following significant picture:

Red blood count	4,120,000
Haemoglobin	78%
White cells	12,500
Polys	51%
Non-lobulated	6.5
Lobulated	44.5
Small lymphocytes	30
Large lymphocytes	10
Large mononuclears	1.5
Eosinophiles	6%

The allergic blood picture once more prompted conservative treatment. In six hours all the signs had practically disappeared. Further skin testing by the intracutaneous method was negative for all foods and inhalents with the exception of carrots which gave a slight moderate reaction. The offending food was removed from his diet and the symptoms promptly disappeared. Another blood picture taken in the quiescent period presented a normal eosinophilia (1.5%). This syndrome was later reproduced by the ingestion of carrots. With the complete elimination of the offending food, there have been no recurrences of any abdominal symptoms.

(Concluded on page 278)

DERMATITIS CAUSED BY NYLON STOCKINGS

EDWARD GIPSTEIN, M.D., *New London, Connecticut*

The Author. A.B., *Harvard, 1927*. M.D., *Jefferson Medical College, 1931*. Senior, Medical Staff and Electrocardiographer, *Lawrence and Memorial Associated Hospitals, 1937 to date*

IN A RECENT issue of the Journal of the American Medical Association, Doctor S. J. Fanburg reported a preliminary study of four cases of dermatitis following the wearing of Nylon stockings. To these four cases I am adding one that has come to my attention recently. I do not agree with Fanburg's observations that the Nylon fabric itself is innocuous, and that only the dye used in the finished product is the irritating agent. In the following case Patch tests were made with the undyed Nylon fabric and with the Nylon stocking itself. In both cases a positive reaction was observed within twenty-four hours. The eruptions were identical in appearance an erythematous papulo-vesicular rash that itched intensely.

An interesting fact in this case is that the patient has had Hay Fever for the past few years; being sensitive to dust, orris powder, timothy and ragweed. Whether or not the dermatitis caused by the Nylon fabric is more common in an individual allergic to some other substance requires further observation and study.

CASE REPORT

Mrs. L. W., aged 20, a housewife, consulted me on July 3, 1940. She complained of severe itching of both her legs,

from the toes to the upper part of both thighs, or the areas covered by the stockings. Examination revealed a pinpoint papulo-vesicular eruption that somewhat resembled the eruption of poison ivy. The eruption was limited to the exact areas covered by the stockings. The patient stated that she had been wearing Nylon hose for about three weeks prior to this eruption. The itching was so severe that she had to be hospitalized for treatment. During her stay in the hospital the dermatitis spread to the abdomen, upper arms, face, ears and neck. This was probably due to the fact that the patient constantly scratched the involved areas and then rubbed her abdomen, face and neck without cleansing her hands. It is interesting to note that the scalp and the soles of the feet remained free of any lesions. After two weeks the eruption slowly disappeared.

The temperature and pulse remained normal. The urine, red blood cell count and white blood cell count were negative. The blood did not show an eosinophilia. A Patch test made with the Nylon stocking and one made with a piece of undyed Nylon fabric were both strongly positive within twenty-four hours.

CONCLUSION

1. It appears fairly certain that in susceptible individuals Nylon stockings will produce a papulo-vesicular dermatitis with intense itching, since only the areas covered by the stockings were at first involved.
2. Patch tests reveal that the Nylon fabric itself, dyed or undyed, is the offending agent.
3. Individuals suffering with a known allergy should use extreme caution in wearing Nylon hose, and, rather than run the risk of developing an annoying dermatitis, should have a Patch test made to determine their susceptibility.

APPENDICITIS SYNDROME

(Continued from page 277)

	W. B. C.	Polys.	Eosinophiles
During Attack	12,500	51%	6%
After Subsidence	10,600	50%	1.5%

SUMMARY

(1) Herein is presented a case of the appendicitis syndrome with characteristic symptoms, signs and laboratory findings, due to carrot sensitivity.

(2) This syndrome requires no surgical intervention. Such treatment often does not affect the clinical picture, for the shock organ may be in the

caecum or terminal ileum.

(3) All such cases, however, must be carefully observed until the syndrome disappears, as infrequently a secondary inflammation of the appendix may result. The persistence of the signs plus an infective differential white count will be of material assistance.

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5. Gay, L. P.—*Journal of Missouri Medical Assoc.* 31, 385, 1934.

CANCER OF THE COLON IN TWINS: A CASE REPORT

J. COLL, M.D., AND H. HUMPHREY, M.D., *Hartford*

The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the JOURNAL. The following from the Hartford Hospital is the fifth in this series. (The Editor.)

Doctor Coll. B.S., *University of Notre Dame, 1935. M.D., Jefferson Medical College, 1940. Intern in Pathology, Hartford Hospital, 1940-1941. Clinical Assistant in Pathology, Yale School of Medicine, 1940 to date*

Doctor Humphrey. B.A., *Colgate University, 1936. M.D., Yale University, 1940. Intern in Pathology, Hartford Hospital, 1940 to date. Clinical Assistant in Pathology, Yale School of Medicine, 1940 to date*

THIS CASE REPORT is to record the simultaneous occurrence of similar malignant tumors in the same organ of, presumably, homologous twins.

G. G., a 55 year old white male had a bilateral inguinal herniorrhaphy performed at Hartford Hospital one year ago. Since then he has had bouts of "gas pains" with a feeling of distension. One week before admission these symptoms became more marked and constipation developed. One day before admission vomiting occurred. Physical examination was not significant. Routine laboratory findings were noncontributory. Gastro-intestinal x-ray examination revealed a lesion with malignant characteristics involving the distal portion of the transverse colon. A Mikulicz type resection was performed on July 21, 1940, and 25 cm. of large bowel removed, in which there was a grade II, annular adenocarcinoma 7 cm. in diameter, which completely encircled the lumen and extended completely through the wall. Involved lymph nodes could not be found. Recovery was uneventful. The colostomy was closed several months later.

During the patient's stay in the hospital it was learned that he had a twin brother living in a nearby city. Upon request, the twin presented himself for study.

H. G. gave a history of bloody stools, occasional abdominal cramps and constipation during the previous six months for which he had been treated for hemorrhoids by his local physician. Physical exam-

ination revealed an old left inguinal herniorrhaphy scar and slight supra-pubic tenderness. Routine laboratory examinations were not remarkable. Proctoscopic examination and gastro-intestinal x-ray examination revealed an ulcerated tumor encircling, but not obstructing, the lumen 15 cm. from the anus. Biopsy showed the growth to be a grade II adenocarcinoma. An abdominal resection was performed on August 19, 1940, and 18 cm. of large bowel removed. The surgical specimen confirmed the preoperative conclusions. The tumor was found to involve the entire thickness of the intestinal wall. Microscopically, metastases to the regional nodes were apparent. The histology was identical to that of the previous case. A permanent colostomy was established. Recovery was uneventful.

McFarland and Meade¹ were able to collect from the literature forty "similar, simultaneous, and symmetrical" tumors occurring in twenty pairs of homologous twins. A malignant tumor of the gastro-intestinal tract was not included in their report. The data here presented indicates: (a) that heredity as a factor in the etiology of tumors should be of more than academic interest to the clinician; (b) that the diagnosis of hemorrhoids to explain intestinal symptoms should be made only after careful examination has ruled out more serious lesions.

REFERENCE

1. McFarland and Meade: *Am. Jour. Med. Sc.* 1932: CLXXXIV, 66.

THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the \$37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

THE CONNECTICUT PEDIATRIC CONSULTING SERVICE

MARTHA L. CLIFFORD, M.D., *Hartford*

The Author. A.B., *University of Colorado, 1930.*
M.D., *University of Colorado, 1933.* M.P.H., *Johns*
Hopkins School of Hygiene and Public Health, 1935.
Director, Bureau of Child Hygiene, Connecticut
State Department of Health

FOR SEVERAL years the Connecticut infant mortality rates have been lower than these rates for the United States as a whole. The challenge to reduce even more the number of infant deaths and to reduce illness in children has stimulated the Public Health Committee of the State Medical Society to recommend in October, 1939, the establishment of a Pediatric Consulting Service under the State Department of Health. As a result, the problem of securing help of qualified pediatricians was approached by conferring with Connecticut physicians who are licentiates of the American Board of Pediatrics and other physicians who have had special training in pediatrics. The records of those who would be willing to serve as consultants have been reviewed by the Pediatric Subcommittee of the Public Health Committee, and the ones recommended have been appointed by the State Department of Health.

Physicians often find in the families they serve some infants and children whose cases call for special study. Some families are able to pay for this special medical study, and others are on relief which includes medical care, but there are a large number of families, especially in the rural communities, for whom special medical services seem unattainable. The family physician may feel that his advice can be of little use because the family situation is impossible economically. In Connecticut the larger cities are supplying clinical services for families of this border economic level, but communities with populations of less than 50,000 have no provision for special medical care of the infants and children of these lower middle income families.

All physicians who are familiar with the Connecticut Obstetrical Consulting Service which started in June, 1937, will see that the Pediatric Consulting Service is similar. The family physician may call on any consultant in the list, and if the family is unable to pay and no means are available for payment of a consultation fee, either through a relief agency or other source, the consultant will be paid a nominal fee from the State Department of Health. The consultation fee will be paid to the pediatric consultants upon receipt of the appropriate form signed by the attending physician and a pediatric consultant. A fee of \$5.00 will be paid for a consultation in the consultant's office. A fee of \$10.00 will be paid to the consultant for a consultation which requires the consultant to travel to the patient. A maximum of \$20.00 for consultation fees is allowed for each case. The consultants will be reimbursed at the rate of five cents per mile for travel expense to and from their offices and the homes of pediatric cases. The service will be limited to communities of less than 50,000 because of the limitation of State funds and because the cities are better able to give adequate medical service than are the smaller communities. The consultation fees are available from the State Department of Health for residents living in communities of less than 50,000 population.

The services are to be carried out in the following manner: A physician in charge of a pediatric case, feeling that consultation with a pediatrician is desirable, calls one of the consultants on the list and asks him to see the case. The financial eligibility of each case is determined by the attending physician who usually knows or can find out if the family is on relief or is able to pay a consultation fee.

The consultant makes an examination and gives his recommendation for treatment to the attending physician. Medical ethics and customary professional practice serve as the basis for this program

and are to be adhered to at all times. A physician requesting consultation will regard the consultant in the same light as he would regard a consultant for any of his other patients.

When treatment recommended by the pediatric consultant involves hospitalization, the case will be sent to a hospital which has been approved for the care of pediatric cases, and the infant or child will be hospitalized on ward service and will be under staff care. Provision has been made for the payment of the hospital bill when hospitalization is recommended by the pediatric consultants. (When the Obstetrical Consulting Service was first proposed in June, 1937, no provision was made for hospitalization of cases requiring hospital care. The obstetrical consultants have found the benefit of their advice limited because of the lack of provision for hospital care. It seems reasonable that if a family is not on relief, and is unable to pay an obstetrical consultant, the same family would be unable to pay an unusual hospital bill. Now provision has been made for the payment of the hospital bill when hospitalization is recommended by the obstetrical consultant.)

The Connecticut Pediatric Consulting Service aims to improve the chances for life and health of many infants and children of parents who are not on relief but who have barely enough to pay for food and shelter and cannot therefore pay for special medical care when needed. Medical science has proved that it can accomplish wonders if properly applied. All scientific reports show that proper application of medical knowledge demands that it be individualized. The Connecticut Pediatric Consulting Service provides for medical attention applied to the individual case.

In summary:

1. The Connecticut Pediatric Consulting Service is a program of the Connecticut State Department of Health prepared with the assistance of the Connecticut State Medical Society.
2. It provides for pediatric consultation for premature infants, and all other infants or children under sixteen years of age who are acutely or chronically ill and who present a diagnostic problem.
3. It is limited to patients of borderline economic level living in towns of less than 50,000 population. (This includes all communities except Hartford, Bridgeport, New Britain, New Haven, Stamford and Waterbury.)
4. The consultant is called directly by the attending physician.

5. The financial eligibility of each case for the consultation fee is determined by the attending physician.

6. The consultant is paid a fee of \$5.00 for a consultation in his office, while a fee of \$10.00 is paid for a consultation which requires travel to the patient. A maximum of \$20.00 is allowed for consultation fees for each case. The consultant is reimbursed for his travel expense at the rate of five cents per mile.

Here Today

No single catastrophe in the United States last year approached the daily average of almost 100 lives lost in automobile accidents, according to a new booklet entitled "Here Today—" just issued by The Travelers Insurance Company. The booklet is the eleventh in a series issued annually and presents a comprehensive analysis of the facts about accidents in which 35,000 persons were killed and more than 1,300,000 others were injured in 1940.

Automobile accidents on an average day last year took twice the number of lives lost in the Kenvil, N. J., powder blast, three times the toll of the Georgia-South Carolina hurricane, and four times that of the Little Falls train wreck or the Lovetsville airplane crash, the report says. The number injured in traffic on an average day exceeded the total casualties of the six major disasters of 1940 combined.

Highlights from the annual report, based on official reports from the 48 states, include the following interesting facts:

Exceeding the speed limit was responsible for 40 per cent of the fatalities and 26 per cent of the injuries in 1940.

Every third victim of a fatal traffic accident last year was a pedestrian.

More than 97 per cent of all drivers involved in accidents had a year or more of operating experience.

Almost 86 per cent of all fatal accidents occurred in clear weather and almost 78 per cent happened when the road surface was dry.

A composite picture of 1940's typical accident driver would show that he was an experienced, middle-aged male and that he was driving a passenger car in good mechanical condition in clear weather during the early evening hours of a Saturday or a Sunday.

PRELIMINARY PROGRAM FOR 149TH ANNUAL MEETING

Hotel Stratfield, Bridgeport

May 20, 21, 22, 1941

The program has been arranged by:

G. GARDINER RUSSELL, *Chairman*, Hartford

FRANCIS G. BLAKE, New Haven

BERKELEY M. PARMELEE, Bridgeport

and

DANIEL C. DARROW, New Haven, *Hezekiah Beardsley Pediatric Club of Connecticut*J. GRADY BOOE, Bridgeport, *Section on Proctology*KARL B. BRETZFELDER, New Haven, *Section on Physical Therapy*OWEN J. GROARK, Bridgeport, *Section on Radiology*WILLIAM J. RYDER, New Haven, *Section on Eye, Ear, Nose and Throat*MARIO L. GAROFALO, New Haven, *Section on Anesthesia*GEORGE A. GOSSELIN, Hartford, *Section on Neurology and Psychiatry*RALPH E. McDONNELL, New Haven, *Section on Dermatology and Syphilology*FRANK S. JONES, Hartford, *Section on Orthopedic Surgery*HARLAN B. PERRINS, New Haven, *Section on Obstetrics and Gynecology*EUGENE F. MESCHTER, Stamford, *Section on Industrial Health*ELEANOR CALVERLY, Hartford, *Women's Medical Society*

and

*Committee on Arrangements from the Fairfield County Medical Association*STANTON R. SMITH, *Chairman*, Bridgeport

CRAWFORD GRISWOLD, Bridgeport

DANIEL B. HARDENBERGH, Bridgeport

MAY 20, 1941

The House of Delegates meets throughout the day commencing at

10:30 A. M. Lunch will be served for members of the House of Delegates and officers of the Society

MAY 21, 1941

- 9:30 A. M. Registration
- 10:00 A. M. General Session, Arthur B. Landry, President, Presiding
Address of Welcome President Fairfield County Medical Association
- 10:10 A. M. Chemotherapy in Pelvic Inflammatory Diseases William E. Studdiford, New York City
- 10:45 A. M. Cancer of the Cervix Catharine Macfarlane, Philadelphia
- 11:20 A. M. Uses and Abuses of Encephalography Cornelius G. Dyke, New York City
- 11:55 A. M. The Relationship of Anesthesia to Surgical Shock Henry K. Beecher, Boston
- 12:30 P. M. Health Plans for Small Industries Anthony J. Lanza, New York City

LUNCHEONS

- 1:15 P. M. Society's Luncheon
Inter-Professional Relations
Speaker, Hugh P. Beirne, Commissioner of Pharmacy, State of Connecticut
- Women's Medical Society Luncheon-Meeting
Report of An Experiment in the Control of Cancer of the Uterus"
Speaker, Catharine Macfarlane, Philadelphia
- Connecticut Hospital Association Luncheon
- 3:00 P. M. Section Meetings
Obstetrics and Gynecology
Chemotherapy of the Pelvic Infections Caused by Hemolytic Streptococcus
Speaker, Dr. William E. Studdiford
- Anesthesia
Fluid Balance in the Pre and Post Operative Patient Jacob H. Fine, Beverly, Massachusetts
Breathing in Anesthesia Wesley Bourne, Montreal, Quebec
- Industrial Health
Program to be announced
- Neurology and Psychiatry
Surgical Treatment of Mental Disorders Walter Freeman, Washington, D. C.
Subject to be announced D. Ewen Cameron, Albany
- 5:00 P. M. Cocktail Hour
- 7:00 P. M. Annual Dinner of the Society
Arthur B. Landry, Toastmaster
Speaker to be announced

MAY 22, 1941

- 9:30 A. M. House of Delegates Meeting
General Session G. Gardiner Russell, Chairman Program Committee, Presiding
- 9:30 A. M. Cancer of the Upper Respiratory Tract LeRoy A. Schall, Boston
- 10:10 A. M. Skin Diseases of Childhood Anthony C. Cipollaro, New York City
- 10:50 A. M. Use of the Miller-Abbott Tube Ross Golden, New York City
- 11:30 A. M. Treatment of Influenza Meningitis Hattie E. Alexander, New York City
- 12:10 M. Sciatica from An Orthopedic Point of View M. Nygaard Smith-Peterson, Boston
- 1:15 P. M. President's Luncheon
Address of Retiring President, Arthur B. Landry,
Introduction of the President, James D. Gold
- 3:00 P. M. Section Meetings
Eye, Ear, Nose and Throat
Rhinology and Oral Surgery, Their Interrelation and the Necessary Coöperation of
Both Specialists Theodor Blum, New York City
Vitamin Therapy in Ophthalmology Arthur M. Yudkin, New Haven
Cavernous Sinus Thrombosis LeRoy A. Schall, Boston
- Orthopedic Surgery
Arthroplasty of the Hip M. N. Smith-Peterson, Boston
- Hezekiah Beardsley Pediatric Club of Connecticut
Experiences in the Treatment of Influenza Meningitis in New Haven
Sydney E. Sinclair, New Haven
- Discussion by Hattie E. Alexander, New York City

MAY 22—*Continued*

Physical Therapy

Physical Therapy in Some Gynecological Conditions

Madge C. L. McGuinness, New York City

Dermatology and Syphilology

Radiology

Radiologic Studies of Diseases of the Small Intestine

Ross Golden, New York City

Proctology

Facts and Fallacies Regarding Proctologic Diseases

Martin S. Kieckner, Allentown

General Medicine—organization meeting

Speaker to be announced

6:00 P. M. Section Dinners

Eye, Ear, Nose and Throat

Orthopedic Surgery

Physical Therapy

Radiology

Dermatology and Syphilology

ORGANIZATIONS MEETING AS GUESTS OF THE CONNECTICUT STATE MEDICAL SOCIETY

The Connecticut Hospital Association, May 21

Hospital Medical Records Librarians' Association of Connecticut, May 21

Connecticut Occupational Therapy Society, May 21

Connecticut Branch, American Association of Medical Social Service Workers, May 22

Womens' Medical Society, May 21

COMMERCIAL EXHIBIT

JOHN H. BUMSTEAD, M.D., *Director*

EXHIBITORS	ADDRESS	SPACE NO.	E. L. Washburn & Company, Inc.	New Haven	12
Parke, Davis & Company	Detroit	1	Bedford Surgical Company, Inc.	Brooklyn	13
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The Sun-Rayed Company	Frankfort, Ind.	4	Petrolagar Laboratories, Inc.	Chicago	16
Nestle's Milk Products, Inc.	New York	5	Surgeons & Physicians Supply Company	Boston	17
H. J. Heinz Company	Pittsburgh	6	Eli Lilly and Company	Indianapolis	18
Scientific Sugars Company	Columbus, Ind.	7	The Borden Company	New York	19
Lederle Laboratories, Inc.	New York	8	The Professional Equipment Company	New Haven	20-21
McKesson & Robbins, Inc.	Bridgeport	9	The D. G. Stoughton Company	Hartford	22
John Wyeth & Brother, Inc.	Philadelphia	10	Philip Morris & Company, Ltd., Inc.	New York	23
Mead Johnson & Company	Evansville, Ind.	11	J. B. Lippincott Company	Philadelphia	

TECHNICAL EXHIBITS

Pharmaceutical Preparation sand Technique

The Connecticut Pharmaceutical Association

The Connecticut Occupational Therapy Society

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month—day of month if weekly—and year.

Used manuscripts will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

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NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physicians.

We shall be glad to know the name of the sender in every instance.

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REPRINTS: Reprints of papers and obituaries may be obtained from the Editor at cost.

EDITORIALS

The Warren Prize Comes to Connecticut

For the first time since the Warren Prize was founded about 1870 it has been awarded to physicians in Connecticut. The 1940 award of five hundred dollars "for the best dissertation, considered worthy of a premium, on some subject in physiology, surgery, or pathological anatomy," was presented to Doctors Ebbe Hoff and Louis H. Nahum of the Yale University School of Medicine. The joint paper, discussing the mechanism of the electrocardiograph, was one of seventeen submitted from various parts of the world. Doctor Nahum has frequently contributed to the Journal scientific articles on pneumonia, renal and cardiac disease. Doctor Hoff will be remembered by our readers for his very interesting contribution in a recent number of the Journal on the organization of medical services in England for the care of civilians injured by enemy air raid attacks.

The Warren Triennial Prize was founded by the late Doctor J. Mason Warren in memory of his father, Doctor John C. Warren, a descendent of the Revolutionary surgeon of the same name. The will

of the founder provides that the accumulated interest of the fund shall be awarded every three years. The initial recipient was Horatio C. Wood, Jr., M.D., of Philadelphia (1871), and subsequently there follows the names of other physicians in Philadelphia, Boston, Baltimore, Schenectady, N. Y., and others in England, Scotland, Ireland, Bavaria, and Italy. Two previous recipients of the Warren Prize now reside in Connecticut, Doctor John F. Fulton, professor of physiology at Yale, and Doctor Wilmot C. Townsend of Hartford. Doctor Fulton, then living in Oxford, England (1925), submitted a paper on "Some Aspects of Musculature Contraction." Doctor Townsend in 1928 shared the prize with Doctor William B. Castle when both were engaged in research at the Thorndike Memorial Laboratory in Boston. Their paper was entitled "Probable Physiological Significance of Achylia-gastrica in the Causation of Pernicious Anemia."

The medical profession in Connecticut is extremely proud of the honor bestowed upon Doctor Hoff and Doctor Nahum who have made such outstanding achievements in their chosen field.

Trigeminal Neuralgia

Major trigeminal neuralgia, (*tic douloureux*), has been recognized as a clinical entity since the time of Hippocrates. The condition was well described by Fothergill (1773) but complete knowledge of its etiology and pathology is still lacking. The studies of Charles Bell (1820) on the function of the nerves of the face resulted, after an interval customary to the profession, in the application of surgical procedures to the *trigeminal nerve* for relief of the painful paroxysms. It was soon evident that periods of symptomatic remission could be obtained by surgical section of the peripheral branches of the trigeminal nerve but recurrent neuralgia appeared coincident with the completion of nerve regeneration. This led to a direct surgical attack upon the gasserian ganglion by Hartley (1892) and Krause (1892), with permanent relief of pain. The early experiences with this operation, because of its high mortality, are still reflected in the opinions of many members of the profession concerning the present form of surgical treatment. A great improvement in the safety of operation was contributed by the introduction of trigeminal root section by Spiller and Frazier (1901); this procedure had previously been done by Victor Horsley (1891). The present surgical treatment, differential root section, [Frazier (1925), Dandy (1925), Stookey (1928)], assures a high percentage of permanent cures with a mortality in the neighborhood of one per cent. Section of the descending trigeminal tract in the medulla has been suggested for certain cases by Sjöqvist (1938).

Alcohol injection of the peripheral trigeminal branches [Schlösser (1903)] gives only temporary relief and is now used chiefly for debilitated patients or for those cases in which the diagnosis is questionable. Alcohol injection of the gasserian ganglion (Harris 1910) has not been widely practiced but would appear to be less satisfactory than trigeminal root section. The conservative *medical* treatment of trichlorethylene inhalations, suggested by Oppenheim (1915), is occasionally effective, particularly in early, mild cases.

As a result of the dramatic effectiveness of thiamin chloride administration in the painful neuropathies associated with vitamin B₁ deficiency, this form of therapy was tried in cases of trigeminal neuralgia [von Lobenstein (1936)]. Favorable reports on this treatment have been published by Borsook, Kremers and Wiggins (1939) while Rose and Jacobson

(1940), using injections of sterile water in their control series, conclude "it is probable that vitamin B₁ has no specific beneficial effect on trigeminal neuralgia."

In spite of the general availability of adequate surgical treatment for patients suffering from major trigeminal neuralgia, the statement of Harvey Cushing is hardly less true today than it was in 1920: "It is a most significant thing that the victims of this dreadful affliction in its severe forms are far more frequently advised to submit to a Gasserian operation by former patients than by a profession which still regards it with misgivings.* . . . There can be no greater tribute to an operative procedure than its recommendation to others from those who have experienced it."

W. J. G.

*Cushing's mortality was 0.6 per cent in a series of 332 gasserian ganglion operations.

S. B. 529

Senator Alfred Bingham has introduced into the upper body of the General Assembly the Health Insurance bill. This bill is sponsored by the American Association for Social Security and originally drafted by its secretary, Abraham Epstein, in collaboration with leading authorities and in particular Professor Herman A. Gray of the New York University Law School. The same bill is now before the New York State Legislature. Since S. B. 529 vitally concerns each and every practitioner of medicine in Connecticut it would not be amiss for each one to fully acquaint himself with the contents of the bill. State Medical Society officers have kept pace with its development since its original draft. A subcommittee of the State Medical Society's Legislative Committee has been studying the Bingham bill (so called in Connecticut) and believes it to be the most sharply delineated kind of class legislation yet proposed.

On the basis of the classification of employees as found in the 1930 census, and estimated for 1940, it is believed that the total cost of health insurance as outlined in this bill would be about \$16,000,000.00. There are some who believe the cost would run even higher. The contribution of the State would represent almost one half of this amount. No one apparently has determined the source from which such an outlay would be derived. The aforementioned senator has at the same time submitted to the present

General Assembly a bill calling for a State income tax.

There are many provisions in S. B. 529 with which physicians in this State may be in disagreement. Conceivably the entire scheme of compulsory health insurance may not appeal to many. The fact remains that the bill would call for a radical departure from some of the fundamental habits of a large number of people, not only those who furnish medical care but those who receive it. Many forms of socialized medicine, whether or not we recognize them as such, are in operation today. It will be of interest to learn the reaction of both capital and labor to such legislation as is proposed in this bill. At the present time employees who would be covered by this bill are already receiving medical care in large quantity, of good quality, and at fair cost levels.

The Connecticut State Medical Society stands ready and willing to do anything within its power to improve medical care in this State. Since the legislation proposed is extremely complex and since no experience in compulsory health insurance obtains in this country, there continues to exist the necessity for open minded study of all aspects of the subject. If such legislation as Senator Bingham proposes is necessary for improvement in medical care there must be a clear cut understanding of the implications involved.

Doctor Sigerist Prescribes

It is not to be denied that Doctor Henry Sigerist, who is the William H. Welch Professor of the History of Medicine at Johns Hopkins, is a distinguished student of the history of medicine in many lands. Whether he is a competent authority to prescribe a formula to cure the ills in the distribution of medical care in America has been debated.

In "Medicine and Human Welfare" (Yale University Press) Doctor Sigerist sets down some plausible arguments for government medicine. "Everybody rich and poor should have all the medical care that science can give. There is only one way of achieving this," says Doctor Sigerist, "the physician must be removed from the sphere of competitive business. We cannot think of a minister of the church, a judge or a professor selling his services in the open market. Private competitive medicine cannot solve the health needs of a nation . . ."

Doctor Sigerist has never ministered to the sick in this, his adopted country, but he has travelled

everywhere and knows many American doctors and he observes: "While some physicians are fully aware of the trends of the time and have the courage to face the problem openly and to seek its best solution, others are afraid of any change." He goes further to say, "I am convinced that medicine, like education, will ultimately become a public service in every civilized country. All trends are in that direction." It is easy to agree with him in that idea and there is something faintly reminiscent about it for in October 1939 this JOURNAL published "I see that the people are coming to look upon medical care as a public utility, like electric power, needed by everyone and necessarily available to meet that need."

When he comes to "practice tomorrow will of necessity be group practice organized around a health station . . .," Doctor Sigerist moves into the sunny fairyland of inexperience, it is a deduction drawn beside the library hearth, not in the night in a New England blizzard.

All this may come "sooner than we commonly expect. The war which broke out in 1939 will destroy the laissez-faire attitude once and for all and will force social adjustments which have been neglected in the past." That sounds like truth for sure and Doctor Sigerist's prognosis may be better than his remedy.

Health Here and In Europe

In the midst of Attorney General Arnold's cudgeling and sniping at the medical profession and the spreading contagion of the American Association for Social Security's support of the spoils system in the practice of medicine by the government, it is refreshing to consider the health record in this country for the year just ended. True, 1940 did not set a new low mark in mortality figures but it does rank with the best health years on record. The Metropolitan Life Insurance Company¹ has found that among its many millions of Industrial policyholders living in the United States and Canada the death rate for 1940 was 7.60 per 1,000, the equal of the lowest figure ever registered for this group.² The decline in mortality rate among policy holders of this large company has been forty per cent between 1911 and 1940 and this has resulted in a great saving of lives at virtually every period of life.

Ten diseases and conditions recorded lower mortality rates in 1940, than in any previous year, name-

ly, measles, scarlet fever, whooping cough, diphtheria, pneumonia, tuberculosis, diarrhea and enteritis, appendicitis, puerperal diseases, and homicide. Influenza and suicide showed an improved mortality rate. Increases in mortality were recorded from diabetes, cancer, and the cardiovascular renal diseases, an indication of the increased proportion of policyholders at the older ages.

We turn to Europe, torn with strife and starving because of a few insanely selfish political leaders. Europe has experienced its worst record in many years. Cerebrospinal meningitis in England during 1940 claimed about 12,500 lives, eight times the mortality for 1939. An influenza epidemic in the first quarter of the year, aided and abetted by war conditions, accounted for five per cent of the deaths and was two thirds above that for the preceding year. Infant mortality for the first quarter rose from 65 to 77 per 1,000 live births. 23,081 civilians were killed in air bombardments in England during 1940, and fatal accidents during the first fifteen months of the year rose to 11,424.

Data on mortality from the Continent is fragmentary. Cerebrospinal meningitis was on the increase. Deaths from typhus rose appreciably, particularly in Roumania. It is to be feared that the frightful breakdown in sanitary conditions that occurred in and after the last war cannot be avoided in this war. Typhoid and dysentery were abnormally high in frequency in certain countries. The outlook for 1941 is extremely uncertain. Crowding in air shelters with poor sanitary conditions in many of them may be the means of spreading communicable and infectious diseases to pandemic proportions. Civilian medical service is already suffering from the inroads of war service requirements. Apprehension is everywhere felt for the health of Europe during this year.

1. Statistical Bull., Metropolitan Life Ins. Co., Jan. 1941.
2. In 1939 statistics.

Watch the National Physicians Committee!

As a part of the general program of education and public enlightenment, the National Physicians Committee has arranged to provide more than 12,000 weekly, bi- and tri-weekly and foreign language newspapers throughout the United States with a weekly "Editorial Service." These articles are short and concise and stress the advantage of our system of independent practice. They will reach more than forty million readers weekly.

The public has become greatly confused over the issues involved in the argument concerning government socialized medicine. Physicians are not opposed to more and better medical care but they are opposed to the attempts to secure this through use of the spoils system. They are opposed to political ventures in medical fields which would inevitably and rapidly reduce public health standards and destroy or hamper essential work in the battle against disease. Political domination of the medical profession would mean that a doctor's political pull was more important than his abilities as a practitioner. It would mean that medicine would become a great new field for political patronage and this, in turn, would mean unnecessary deaths, unnecessary suffering, unnecessary illness.

Watch the National Physicians Committee! It represents your patients' welfare and your own interests in maintaining the steady progress of medical science.

Erratum

"The Health of the Carolinas," page 179, volume 5, number 3, March 1941, carries the statement that Carl V. Reynolds is governor of North Carolina. Doctor Reynolds is State Health Officer. The governor is the Honorable W. L. Broughton. All of this we knew but for some unknown reason the facts were incorrectly stated. Our apologies to Governor Broughton.

YOU ASKED FOR IT: — The Professional Equipment Company of New Haven announces that they have a new Taylor Pavaex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

NEW HAVEN

Annual Meetings County Associations

Hartford County—Tuesday, April 1st, Hunt Memorial Building, Hartford.

12:00 P. M. Clinic, Hartford Hospital.

4:00 P. M. Annual business meeting, Hunt Memorial Building.

6:00 P. M. Dinner, Hartford Club.

8:00 P. M. Scientific session, Hunt Memorial Building. Speaker, William Dameshek, M.D., Assistant Professor of Medicine, Tufts College Medical School.

New London County—Thursday, April 3rd, The Seaside, Waterford, 4:00 P. M.

Speaker, George F. Cahill, M.D., Professor of Urology, College of Physicians and Surgeons, New York, "Urinary Infections."

Fairfield County—Tuesday, April 8th, Stratfield Hotel, Bridgeport.

Middlesex County—Thursday, April 10th, Cromwell Hall, Cromwell.

Speaker, Lyle A. Baker, M.D., Assistant in Medicine, Massachusetts General Hospital, Boston, "The Changing Concept of Hypertension."

Tolland County—Tuesday, April 15th, Old Homestead, Somers, 6:30 P. M.

Speaker, Orpheus J. Bizzozero, Attending Physician, Waterbury Hospital, "The Clinical Aspects of Ovarian Hormones."

Windham County—Thursday, April 17th, Putnam Inn, Putnam, 12:30 P. M.

Speaker, Ralph L. Gilman, Chief of Medical Service, Windham Community Memorial Hospital, Willimantic; "The Physicians of Windham County in the Eighteenth Century."

Litchfield County—

New Haven County—Thursday, April 24th, New Haven Country Club, New Haven, 4:00 P. M.

Speaker, John F. Fulton, Sterling Professor of Physiology, Yale School of Medicine.

The Council Meets

The March meeting of the Council was held at the Society's office on March 12. There were present Doctors: James R. Miller, Arthur B. Landry, James D. Gold, Stanley B. Weld, George H. Gildersleeve, Robert C. Paine, Thomas P. Murdock, George Blumer, Charles T. LaMoure, Edward J. Whalen, Creighton Barker. Absent: Doctors Hugh B. Campbell, Charles H. Turkington, Samuel F. Mullins, Alfred N. Sweet.

The Legislative Committee was directed to represent the Society in the hearing on S. B. 529—Health Insurance—which was held on Friday, March 14th. Upon recommendation of the Committee on Public Policy and Legislation the Council authorized the representatives of the Society to present to the Committee of the Legislature the Society's opinion with respect to health insurance as follows:

1. The Society is interested and will further any reasonable measure that will benefit the health of the people of Connecticut and improve the distribution of medical care within the State.

2. The Society is of the opinion that since there is no experience with compulsory health insurance in America that the State of Connecticut should proceed with caution and that a thorough study of the subject as it applies to this State should be made before definite legislative action may be properly considered.

3. The Society expresses its willingness to co-operate to the fullest extent of its skill and resources with the State agency that is directed to study the need for and application of compulsory health insurance in this State.

The proposed Principles and Recommendations of the joint conference committee of this Society and the Connecticut Pharmaceutical Association were again presented for discussion and final action upon this subject delayed until a later meeting.

The Council authorized Doctor Joseph H. Howard, the delegate to the Connecticut State Den-

tal Association to propose the formation of a joint conference committee between this Society and the Dental Association.

The remainder of the meeting was concerned with nominations of officers and committees for the year 1941-1942.

The Health Insurance Hearing

The hearing on S. B. 529 was held on March 14 before the Senate Committee on State Administration and the joint Committee on the Judiciary. The Old Senate Chamber in the Capitol was crowded. Mr. Abraham Epstein, the Socialist representative in Congress from New York City and an active person in the American Association for Social Security was the chief exponent of the cause of compulsory health insurance. Mr. Epstein was briefly supported by a representative of the American Federation of Labor of the Committee of Industrial Organization. The Connecticut State Medical Society was represented by the Chairman of the Committee on Public Policy and Legislation, the President, and the Chairman of the Council who presented the expressions authorized by the Council.

Pan American League Against Cancer

An organization which is to carry on in the Western Hemisphere the scientific and social work of the International Union Against Cancer has been incorporated under the laws of the State of New York as the PAN-AMERICAN LEAGUE AGAINST CANCER. One may recall that the International Union Against Cancer was an organization actively engaged in the fight against cancer on an international scale. Fifty-two countries were affiliated with the International Union which maintained headquarters at Paris, France, until recent events.

The creation of the PAN-AMERICAN LEAGUE is due to the efforts of Professor Francis Carter Wood of New York, Professor Angel H. Roffo of Buenos Aires and Mr. Boris Pregel, respectively vice-president, member of the Board of Directors and president of the Finance Committee of the International Union Against Cancer, with the coöperation of many other outstanding personalities in the field of cancer and members of the International Union Against Cancer, throughout the American conti-

nent. Professor Francis Carter Wood headed the Organizing Committee of the new League and the presidency will be assumed by Angel H. Roffo, Professor of Cancerology at the University of Buenos Aires, Founder and Director of the Instituto de Medicina Experimental, the leading institution for cancer research in Latin America.

The aims of the new organization, as outlined in the certificate of incorporation are:

- a) To promote and encourage the international fight against cancer.
- b) To coördinate in the countries of the American continent the scientific study and research in cancer and to publish and disseminate information thereon.
- c) To engage in social welfare work in its relation to the problem of cancer.
- d) To promote the establishment of national organizations throughout the Western Hemisphere to engage in similar activities.

The comprehensive program of the activities of the PAN-AMERICAN LEAGUE will include, it is hoped:

- a) Publication of a Pan-American Cancer Journal to serve as a permanent medium of information on the activities of the League and its affiliated national organizations.
- b) Organization and maintenance of a Pan-American center of information and statistics on cancer.
- c) Establishment of a Pan-American system of fellowships, scholarships, endowments and exchange of scholars and students.
- d) Among its immediate projects are:

The organization of a *First Pan-American Cancer Week* to be held simultaneously in all the countries of the American continent on the pattern of the First International Cancer Week of 1938, which was held simultaneously in forty countries throughout the world. The holding of a *Pan-American Congress for the Scientific and Social Fight Against Cancer*. It is anticipated that this Congress will take place at Buenos Aires in 1942 under the chairmanship of Professor Angel H. Roffo and the honorary presidency of His Excellency, Doctor Roberto M. Ortiz, President of the Argentine Republic.

The Congress will coincide with an *Exhibition* devoted to the scientific, social and technical aspects of the fight against cancer, sponsored by the PAN-AMERICAN LEAGUE AGAINST CANCER.

THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

Bridgeport Hospital, Bridgeport

Nurses' Home Dedicated to Miss Elizabeth Oliver

On Sunday afternoon, February 9, 1941, a dedication ceremony was held at the nurses' home of the Bridgeport Hospital to honor the memory of Elizabeth Oliver, an alumna of the school. Miss Oliver had served the hospital as director of nurses for about eight years (1910-1918) and the residence is now to be known as the ELIZABETH OLIVER HALL.

An address was delivered by Doctor Daniel P. Griffin in which a very complete history was given of the hospital and the school of nursing, and a fitting tribute paid to Miss Oliver. Following this address a beautiful picture of Miss Oliver and tablet erected in her memory were unveiled.

This was followed by a presentation to the superintendent of a check to the amount of five hundred dollars (\$500.) which is to be used for the furnishing of one of the rooms in the private pavilion of the hospital. The Alumnae Association has also just completed payment for an endowed room in the hospital for its members. This makes the total amount presented to the hospital by the Alumnae Association \$25,000.00.

Note: The *Bridgeport Life*, published weekly by the Bridgeport Publishing Company, devoted nearly a full page to this dedication in which much of the history of the development of the Bridgeport Hospital was sketched. Our members should ask Mr. Bartine for a copy.

On February 20 our colleague, Mr. Bartine, submitted his annual report to the Board of Directors of Bridgeport Hospital, a copy of which he sent to the Editor. I wish we could present that report in full because it is a fine example of what a superintendent's report should be to his Board of Directors and also is a fine presentation of the work of that institution.

"TO THE MEMBERS OF THE BOARD OF DIRECTORS:

"In presenting the annual report of the Bridgeport Hospital for the year 1940, it is interesting to report that it has undoubtedly been the most important year in the history of our institution in that the number of patients admitted has increased from 10,583 last year to 11,112 this year. The number of days care given has increased from 116,352 last year to

127,525 this year. The average daily census has increased from 318.7 last year, to 348.4 this year. There has been a considerable decrease in the operating deficit from \$87,290.67 last year to \$50,217.96 this year. The cost per patient per day in 1939 was \$5.04, and in 1940 it was \$4.91. It is interesting to note that the hospital's average cost for a patient's stay in the institution was \$54.88; in 1899, over forty years ago, the cost was \$44.88. It is quite remarkable, when you consider the care and attention that were given and the lower costs of forty years ago as compared with present day costs, to learn that there is an increase of only \$10.00 in the cost per patient. This, of course, is due to the fact that over forty years ago a patient remained 34 days in the hospital, and today the average stay is slightly over 11 days. This decrease is due to the many advances that have been made in medical and nursing care as well as the administrative practices in the hospitals of today.

"In the year 1939 the operating expenses were \$585,976.00 and in 1940 the operating expenses were \$625,419.80, an increase of \$39,443.80. The operating income for 1939 was \$498,685.33 and the operating income for 1940 was \$575,201.84, an increase of \$76,516.51. The per capita cost even during this year of advancing prices was 13 cents less per day per patient than in 1939.

"To meet the operating deficit for the year 1940 funds were provided from the following: State of Connecticut grant amounting to \$17,500; Community Chest appropriation amounting to \$21,778.00; interest from endowment fund amounting to \$17,161.84; interest from invested funds amounting to \$33,799.94; and real estate amounting to \$1,592.45; making a total of \$91,832.23. A provision for the depreciation of hospital equipment amounted to \$16,310.74, and the depreciation on buildings amounted to \$28,299.18. The actual deficit from the operative department of the hospital and the capital funds amounted to \$1,468.17.

"You will recall the financial difficulties that the Bridgeport Hospital experienced approximately ten years ago. At that time your President, Officers, Executive Committee and Administrator planned a program to place the hospital on a firm financial footing. It is the belief of your superintendent that this program has now been accomplished with the understanding, however, that the hospital should continue to forge ahead, not only from a financial aspect but in its physical development as well as its medical and nursing progress. It was in 1914 that the present operating unit was constructed. At that time the hospital admitted 3,000 patients a year and gave 52,671 days of care. The average days stay in the institution was 16 days. During 1914, 1,243 operations were performed. In 1940, the total number of patients admitted was 11,112, 127,525 days of care were given, the average stay in the hospital was 11.2 days, and the number

of operations performed was 3,956 (in the main operating rooms). You will observe that the number of patients admitted to the hospital has increased 270% and the increase in the number of operations is 219%. The above figures indicate the growth of the operating unit during the past 25 years, and we must look forward to the activities of the future."

Like all of our other institutions, Mr. Bartine goes on to direct the attention of his Board to the needs for additional buildings and gives them statistical figures and devotes several pages to expressing his thanks and appreciation for the assistance given to him and to the hospital by various groups of people in and about Bridgeport.

Charlotte Hungerford Hospital

The Annual card party of the Charlotte Hungerford Hospital Auxiliary was held in the Auditorium of the hospital on February 12. The general chairman in charge of arrangements was Mrs. William A. Gleason. Assisting her in various capacities were President, Mrs. Charles E. Bennett, Mrs. Robert Lake, Mrs. William Mulcunry, Mrs. Emil Pulver, Mrs. Alfred Lawton, Mrs. Will Griswold, Miss Frieda Ritcey, Mrs. John Scollay and Miss Mary Gleeson. Following an afternoon of cards at 100 tables, there was a sale of candy. Following the usual custom, in addition to the party held at the hospital, groups met in their homes and held small parties for this benefit.

On February 17 the regular monthly meeting of the Executive Committee of the Board of Governors of the Charlotte Hungerford Hospital was held at 4:30 P. M. for the reception of reports of the activities of the various departments of the hospital for the month of January, 1941.

The Chairman, President, Francis H. Griffiths, of the Board of Governors presided. Following this meeting, a meeting of the Executive Committee and representatives of the Executive Committee of the Staff was held.

The Health Officer, Doctor Elias Pratt, who imposed a ban on visitors at the hospital because of the prevalence of influenza, on January 17, lifted the ban on Friday, February 7.

On February 17 the members of the Dental Staff of the Charlotte Hungerford Hospital met for the purpose of organization and general discussion. This group was called together by Doctor Alfred Guildford.

Danbury Hospital, Danbury

Our progressive colleague, Miss Anna M. Griffin, sent us a clipping from a local newspaper relative to capping exercises of the 1943 class of nurses held recently in the Nurses' Home. Sixteen students were advanced, among these at least half were residents of that city. An address was given by Mr. F. Ward DeKlyn, Business Manager of the hospital, while many parents and friends were in attendance at the ceremony.

The hospital training school now has an enrollment of forty-six students—fifteen seniors, fifteen juniors, and sixteen freshmen.

It is worthy of comment when any hospital maintains such friendly relations with the local people.

Grace Hospital, New Haven

On Thursday, March 6th, nearly one hundred physicians, representing tumor clinics throughout the state, attended a State Tumor Clinic at Grace Hospital where papers were presented by Doctors William Mendelsohn, Ralph W. Nichols, Samuel Spinner, and William G. H. Dobbs. These papers were thoroughly discussed by the physicians in attendance. The papers are being published in another section of the State Journal but we are taking the liberty of submitting some extracts from the paper submitted by Doctor Mendelsohn which we think may be of interest. The papers of Doctors Spinner, Dobbs and Nichols dealt entirely with cancer of the stomach and studies made of these cases which had been treated at Grace Hospital. It was one of the best attended State Tumor Clinics that has been held in a long time and we were very glad indeed to welcome members of this group.

GENERAL CONSIDERATIONS REGARDING THE CANCER PROBLEM IN METROPOLITAN NEW HAVEN

WILLIAM MENDELSON, M.D.

Cancer is the second highest cause of death in New Haven, heart disease being the first. Statistics show that this same condition exists throughout the United States Registration Area. It is also true that cancer is essentially a disease of late adult life, only infrequently attacking persons below forty years of age.

Cancer mortality appears to be unevenly distributed throughout the United States. Here in New England we have the highest rates while the lowest rates are found in the southern and west central

areas. It is interesting to note that one of the highest cancer mortality rates of any city in the United States was recorded for New Haven during the year 1934 (180 deaths per 100,000 population). The number of cancer deaths occurring in this city between the years 1920 and 1934 averaged approximately 239 per year.

Because cancer is not a reportable disease, no index of its prevalence has been accurately determined. It has been estimated, however, that for every death from cancer there exists at least three living cases of the disease.

Each year the number of deaths show a decided increase. At first glance, this appears to be quite alarming and discouraging and would tend to imply that cancer is becoming more virulent. However, a closer examination of the statistics reveals that this is not true and the increase is, for the most part, more apparent than real. It is essentially a disease of later adult life and, therefore, its mortality rate is influenced to a considerable degree by the age composition of the population. Wherever there are large numbers of older people a correspondingly higher number of deaths may be expected. It is this factor which undoubtedly contributes to the excessive mortality in the New England States because the proportion of elderly people residing in this area is known to be large.

An interesting example which illustrates this concept is found in New Haven. Statistics reveal that the cancer mortality rate among the foreign born is considerably higher than among those whose parents were born in New Haven. When this statement is analyzed, it is found that among the foreign born there are very few persons below the age of thirty four years; the largest number are much older and fall into the age group in which cancer is most prevalent. From this analysis it becomes clear why a higher mortality rate is to be expected.

The annually increasing cancer mortality rate for the United States can, for the most part, be attributed to this factor of age. The recent census shows that the population is definitely growing older. During the past three decades, the reduction in certain diseases, notably infant diarrhea, smallpox, diphtheria, tuberculosis and, more recently, pneumonia, has tended to increase the span of life.

The Census Bureau reports the average American is 28.9 years old. In 1940, the average American was two and one half years older than in 1930 and six

years older than in 1900. There was a decline in the number of persons under twenty years; a small increase in those between twenty and forty-five years, but a large increase in those people sixty-five years or older. The Census Bureau estimated that the number of persons sixty-five years or older increased from 6,633,805 in 1930 to 8,956,206 in 1940.

Although vast sums have been expended in an effort to discover the cause of cancer, no answer has yet been found and there is, therefore, no known way to prevent it. However, considerable progress has been made in its treatment by the use of x-ray, radium and surgery. Many cases can be cured, but the public must be made to realize that a doctor must be consulted as soon as cancer is suspected and that it is not a hopeless condition. It is the cases that are seen early that can be completely cured and only in this way can the mortality rate be reduced.

Grace Hospital was very proud and very happy to receive a letter from the Committee on Medical Education and Hospitals of the American Medical Association recently, informing them that they had been fully approved for Residency in Gynecology and Obstetrics.

Hartford Hospital

Because of some shortage of graduate nurses for several years and the certainty that the defense program would remove a considerable number from their present activities, a refresher course for graduate nurses was instituted last November 18. Those enrolled had been out of the active practice of nursing for some years, but had all been previously registered in some state. They came from eleven different schools.

The course consisted of thirty six hours of lectures by members of the medical and nursing staffs, covering the various fields, and one hundred and forty four hours of practical work in the wards. The latter was on a rotating basis.

On February 21 certificates were presented to thirty three nurses who had satisfactorily completed the course. Following this the "Refreshers" gave a tea for the nursing and medical staffs, the School of Nursing Committee and the House Staff.

The "Refreshers" were called by many different titles during their course. Perhaps the most amusing of these was "The Foxy Grandmas."

It was interesting to observe their reactions as

they progressed. At first most of them felt that they had forgotten nearly all they ever knew about nursing, but before long they were right back in harness; and on completion of the course appeared to be fully prepared to go to work.

Only one or two of the group expressed the intention of resuming the practice of nursing for financial reasons. The others are standing by to help out when needed. It is planned now to have them return for a few hours' work on the wards each month, to keep their hand in. This reserve corps gives a great feeling of confidence to the hospital and to the community.

Hartford Municipal Hospital, Hartford

*The Hartford Public Library Serves the
Municipal Hospital*

WILLIAM J. RYAN, *Superintendent*

In recent years an increasing number of public libraries have become alive to the possibility and necessity of providing library service to patients confined to hospitals. In the years since the first World War, when the value of the right kind of reading matter was so often demonstrated, the problem of supplying books to the sick has become a science in itself. Modern science recognizes the value of carefully selected reading matter. Whether or not one fully accepts the theory of interactionism, everyone agrees that the proper mental attitude is of utmost importance for the well being of the patient, and that no patient can achieve a rapid and complete recovery if he is continually worried and mentally upset.

In his recently published book, "More Years For the Asking," Doctor Steincrohn expresses this very well when he says: "Any patient who is ill is apprehensive about the outcome of his illness—No man can be taken out of his daily routine for a few days or weeks without becoming anxious about his problems as he lies helplessly in bed. In fact, his problems become exaggerated. Even though not greatly concerned about his illness, he will worry about his job, his financial condition, or the anxiety he is causing his family . . . it is essential that all individuals who must remain in bed for any length of time be made as happy as possible."

In the summer of 1937, library service was offered to the Hartford Municipal Hospital and eagerly accepted by the administrative staff. Months of preparation were spent buying books and studying methods used in some of the outstanding hospital



libraries in this part of the county. In October the library was opened. Its success has been rather amazing.

In the past three years, we have circulated over 100,000 books and magazines to the patients, the people in the Municipal Home, and to the hospital personnel. Each patient is visited twice a week and given as many books and magazines as he may wish to read. Requested books which we do not have are sent out from the Main Library three times a week. While most patients prefer diverting or amusing reading, it is not at all unusual to have requests for books on machine shop practice, gardening, philosophy, economics, astronomy and even cook books and books on interior decoration. Some time ago we had a patient who had an advanced case of cancer and who was unusually depressed. We asked him to read "Fear" by John Rathbone Oliver. It changed the whole train of his thoughts and the next time we visited that section of the hospital he told us that he was going to make an effort to take up an old hobby, violin making. Books on the subject were sent out from the Main Library and for months he was kept happy making and repairing violins.

Special discrimination is used in selecting books for our hospital library. While emphasis is placed on buying the newest and most attractive books, it must be remembered that the "best-seller" list is not a criterion of worth for people who are ill, since many of them are depressing and would probably do more harm than good. "Grapes of Wrath" and "Native Son" are altogether too depressing and sordid for more sick people. "Rebecca" to the casual reader is a fascinating story, but it will be remembered that Rebecca herself, knowing she had cancer, willed her own death in what was practically suicide. "The Citadel" tells vividly how a patient unnecessarily dies on the operating table at the hands of an



incompetent surgeon. Books like these are dynamite, to be used discriminately, if at all. Proportionately, we buy more new fiction for the Municipal Hospital than for any other part of the library, but these books are carefully read and even more carefully circulated. The library subscribes to many of the more popular magazines and buys hundreds of others which the Post Office is unable to deliver. Patients who are too sick to read a long book or whose eyes are too weak, are delighted to be given magazines, especially picture magazines like "Life" or "The National Geographic."

The women in the Municipal Home are visited twice a week just as the patients are. We know that the library service had added appreciably to their happiness. We circulate books to the men through their social worker who comes to the library every day with a long list of requests. The social workers say that the men have shown a tendency to be more contented and in better mental condition since the service has been made available.

The library rooms are open certain hours every

day for the hospital personnel and on one evening so the night nurses may also borrow books. The library feels that library service to the staff is an important phase of its work because people who work as they do need the relaxation or stimulation that books can give. We take pride in the fact that practically every person on the staff is a library patron. By special agreement with the Walter R. Steiner Medical Library, we are able to obtain medical books for the interne staff.

This service is most important to the happiness of patients and staff members too, and it is an essential part of the hospital's excellent work of restoring health to the citizens of Hartford.

Litchfield County Hospital, Winsted

We are very late and very amiss in welcoming to our group Mr. Herbert N. Morford who has been Superintendent of the Litchfield County Hospital since December 1, 1940.

A letter from Miss Maude E. Wise who was formerly Superintendent brought this matter to our attention. Miss Wise is now in DuBois, Pennsylvania, and writes that she misses Connecticut very much and would be glad to have any of us give her any information regarding any vacancies that we may know of in New England.

As we go to press we are preparing to attend a meeting at Hartford on Tuesday, March 18th. Your Association will be represented by Mr. Geeter's Committee on Compensation Rates and by your Board of Trustees. They will meet with the Compensation Commissioners and representatives of the insurance companies. It is expected that our Secretary will furnish our members with details of that meeting at a later date.

The Advisory Committee to the Plan for Hospital Care met recently in the office of the chairman, Mr. James Hamilton, at New Haven Hospital for a discussion with Mr. Parnall, chairman of the Plan, relative to the report of that organization after which it was decided that the Advisory Committee should immediately proceed with securing figures on which to base future discussions relative to increased payment to the hospitals by the Plan, especially for the care of maternity patients. The opinion was expressed by those in attendance that the hospitals were incurring a definite loss on maternity patients as they were taken care of through the Plan.

MEDICAL PREPAREDNESS SECTION

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic

GEORGE M. SMITH, M.D., State Chairman, 258 Church Street, New Haven, Conn.

Changes in Selective Service Organization

New Haven Advisory Board

Louis H. Nahum, New Haven, to be acting chairman during the absence of George Blumer.

Richard M. Goldstein, New Haven, added as consultant in psychiatry.

Hartford Advisory Board

Henry L. Birge, Hartford, added as consultant in ophthalmology.

Board 4B

B. Baylis Earle, Glastonbury, added as alternate examiner.

Board 21B

Joseph C. Quatrano, Bridgeport, to be examiner in place of Stanton R. Smith, resigned.

Charles B. Gaffney, Bridgeport, appointed as alternate examiner.

I. Sidney Zaur, Bridgeport, appointed as alternate examiner.

Board 35

Donald M. Beckwith, Rockville, appointed alternate examiner in place of John P. Hanley, Stafford Springs, resigned.

Connecticut Physicians Ordered to Active Duty

*Ralph H. Edson, Shelton.

*Albert E. Herrmann, Waterbury.

*Angelo A. Lo Vetere, Kensington.

Arthur B. Sullivan, West Hartford.

*Members Connecticut State Medical Society.

The Murray Bill for the Deferment of Physicians In Selective Service

S. 783, introduced by Senator Murray, Montana, February 6. A bill to amend the Selective Training and Service Act of 1940. Pending in the Senate Committee on Military Affairs.

This bill was introduced, apparently, as a substi-

tute for the former bill introduced by Senator Murray, S. 197. The bill provides, among other things, that any individual selected for training and service who is a graduate of a medical school and is eligible as such a graduate for examinations given by the National Board of Medical Examiners or who was so eligible at the time of his graduation, or who is a graduate of a school of dentistry or holds a degree of doctor of dental surgery or doctor of dental medicine and who holds a license to practice medicine, surgery, or dentistry in any State, Territory, or possession and is engaged in such practice at the time of his selection and whose physical and mental fitness for such training and service has been satisfactorily determined, shall, in lieu of induction into the land or naval forces of the United States, be commissioned an officer in the Medical Department Reserve, Officers' Reserve Corps, and ordered into active military service as provided by law.

This bill further provides that (1) students who are preparing for the degree of doctor of medicine or bachelor of medicine at medical schools, (2) students who are preparing for the degree of doctor of dental surgery or doctor of dental medicine at dental schools, (3) hospital interns and resident physicians and surgeons who are graduates of medical schools and are eligible as such graduates for the examinations given by the National Board of Medical Examiners or who were so eligible at the time of their graduation from such medical schools, (4) hospital dental interns and resident dentists who are graduates of schools of dentistry or hold degrees of doctor of dental surgery or doctor of dental medicine, and (5) teachers at medical and dental schools shall be exempt from training and service, but not from registration, under the Selective Training and Service Act.

Furthermore, the bill proposes, any such medical or dental student, hospital intern, or resident physician, surgeon, or dentist, or medical or dental school

teacher, who is a member of a reserve component of the land or naval forces of the United States, shall not be ordered or called to active duty or into active service in any of such forces, except in time of war.

Any person already called into service who if the pending bill had been enacted would have been exempt from such service, shall, it is proposed, be discharged on his own request.

Committee on Preparedness Meets

The Society's Committee on Medical Preparedness is meeting frequently. It met on February 26 in conference with the Commissioner of State Police and General Wadhams of the State Defense Commission. At that time the State organization for disaster relief was considered in detail. The Committee met again on March 5 for the purpose of considering the operation of medical examinations under the Selective Service. Major William B. Smith of the Selective Service Board met with the Committee and outlined the past and future operation of the draft.

County Committees On Defense Named

The County Chairmen on Medical Defense will coöperate in the development of disaster relief plans with the County Committees that have been established by the Commissioner of State Police. These Committees are as follows:

County Committees Established by Edward J. Hickey, Commissioner of State Police

(It is understood that the County Chairmen on Preparedness for The Connecticut State Medical Society will become members of these committees.)

FAIRFIELD COUNTY: Chief C. Wheeler, Bridgeport, P. D., J. Loughlin, Lt. W. Bushy S. P.-Westport, Lt. L. Carroll S. P.-Ridgefield, A. Bennett, Charles Volk, S. Potter, J. McNamara, Lt. T. Moran.

HARTFORD COUNTY: Dep. Chief M. Godfrey, Hartford, P. D., Chief Wm. Hart, W. Sandstrom, Michael Keena, Lt. Paul Lavin S. P., T. H. Donnelly, Leslie Hale, A. J. Gaffney, John Ashmead, Insp. F. Starkel, S. P., Morgan Farrell.

LITCHFIELD COUNTY: Chief Wm. Mulcahy, Winsted, P. D., Edwin Pequignot, John Griffin, Lt. F. Brandt S. P. at Canaan.

MIDDLESEX COUNTY: Chief C. Anderson, Middletown, P. D., George Smith, Chief H. Ryan, Lt. I. Schubert S. P.-Westbrook.

NEW HAVEN COUNTY: Chief P. Smith, New Haven, P. D., M. Carroll, Wm. Roach, J. Cavanaugh,

James Swan, J. McGrath, Lt. Schatzman of the State Police-B. Falls.

NEW LONDON COUNTY: Chief W. Babcock, New London, P. D., Thomas Shipman, Lt. A. Whitmarsh, Lt. R. Pettengill S. P.-Groton and Colchester.

TOLLAND COUNTY: Chairman, Lt. H. Hulbert S. P.-Stafford Springs, Secretary, P. Dowgewicz, George Milne, Burt Hall.

WINDHAM COUNTY: Capt. H. Wallen, Putnam, P. D., Rowe Wheeler, C. Reynolds, Lt. R. Urganhart of the State Police.

Note—S. P. denotes State Police Officials.

Nurses' Committees

Information has been received from Margaret K. Stack, Executive Secretary of The Connecticut State Nurses' Association, concerning the county chairmen on nursing in the preparedness program.

New Haven: Irma E. Reeve, 35 Elm St., New Haven.

Hartford: Marion H. Douglas, 57 Forest St., Hartford.

New London: Gertrude Osborne, 31 Church St., New London.

Middlesex: Lucy Foley, 51 Broad St., Middletown.

Windham: Esther Welles, 2 Ballou St., Putnam.

Fairfield: Amelia Meyersieck, 297 Golden Hill St., Bridgeport.

Litchfield: Harriet Parker, 157 Litchfield St., Torrington.

Tolland: Margaret B. White, Box 13, Eagleville.

The National Health and Medical Committee

The importance of the health of the nation in the broad program of national defense was recognized by many persons, and their efforts during the spring and summer of 1940 finally succeeded in securing for medicine an appropriate position in the great emergency undertaking. With the approval of the President, the Council of National Defense on September 19, 1940, established, "as a subordinate body to the Council, a committee to be known as the Health and Medical Committee." This committee consisted of Doctor Irvin Abell, chairman; the Surgeon General of the Army (Major General James C. Magee); the Surgeon General of the Navy (Rear Admiral Ross T. McIntire); the Surgeon General of the United States Public Health Service (Doctor Thomas Parran), and the chairman of the Division of

Medical Sciences of the National Research Council (Doctor Lewis H. Weed). Vacancies occurring in the membership of the committee are to be filled by appointment of the Council with the approval of the President.

The order establishing the Health and Medical Committee stated:

It will be the responsibility of the Committee to advise the Council of National Defense regarding the health and medical aspects of National Defense and to coördinate health and medical activities affecting national defense. In carrying out its functions, the Committee may (a) utilize, to the extent that such facilities are available for such purpose, the laboratories, equipment and services of the Medical Departments of the Army and Navy, of the Public Health Service, and of other government institutions; and (b) within the limits of the appropriations allocated to it, to contract with and transfer funds to such institutions, and to enter into contracts and agreements with individuals or educational or scientific institutions for studies, experimental investigations and reports.

The early meetings of the Health and Medical Committee were concerned with budgetary problems, and the Bureau of the Budget was asked for a sum of money to finance administrative functions and necessary studies, research projects and travel expenses for the fiscal year ending June 30, 1941.

To fulfill its duties of coördinating health and medical activities affecting national defense, the Health and Medical Committee appointed six subcommittees, which represent large sectors of medical interests.

The Subcommittee on Dentistry consists of Doctor C. Willard Canaliier, Washington, D. C., chairman; Doctor Leroy Miner, Boston; Doctor Frederick B. Noyes, Chicago; Doctor John T. O'Rourke, Louisville, Ky., and Doctor Guy S. Millberry, San Francisco. This committee reported that the American Dental Association had undertaken the listing and classification of all dentists. The dental services for the civilian population surrounding industrial centers and military establishments were discussed, and a study was authorized of the number of dentists within a 30 mile radius of such locations.

The Subcommittee on Medical Education consists of: Doctor C. Sidney Burwell, Boston, chairman; Doctor Willard C. Rappleye, New York; Doctor J. H. Musser, New Orleans; Doctor H. S. Diehl, Minneapolis, and Doctor L. R. Chandler, San Fran-

cisco. The deferment of military service for medical students in good standing in all approved medical schools and the deferment of military service during one year of internship were recommended at the meeting of this subcommittee. The members also discussed the possible modifications of medical curriculums.

The Subcommittee on Hospitals consists of: Doctor Winford Smith, Baltimore, chairman; Doctor Nathaniel Faxon, Boston; Doctor C. W. Munger, New York; Doctor M. T. MacEachern, Chicago, and Father Alphonso M. Schwitalla, St. Louis. The status of residents and interns in relation to the Selective Service Law was discussed and the need of beds for the hospitalization of neuropsychiatric and tuberculous patients was considered by this subcommittee.

The Subcommittee on Industrial Medicine consists of: Doctor Clarence D. Selby, Detroit, chairman; Doctor A. J. Lanza, New York; Doctor William P. Yant, Pittsburgh; Doctor Lloyd Noland, Birmingham, Ala.; Mr. Philip Drinker, Boston; Doctor George M. Smith, New Haven, Conn., and Doctor E. C. Holmblad, Chicago. This subcommittee has held two meetings. The need for well trained physicians and engineers in industrial medicine was emphasized. An outline for a three months' training course was submitted, and the control of various industrial hazards was considered.

The Subcommittee on Negro Health consists of: Doctor M. O. Bousfield, Chicago, chairman; Doctor Russell A. Dixon, Washington, D. C.; Mrs. Mabel K. Staupers, New York; Mr. A. W. Dent, New Orleans, and Doctor A. N. Vaughn, St. Louis. Fundamental health problems were considered, and the need for scholarships was emphasized to encourage students to study medicine.

The Subcommittee on Nursing consists of: Miss Mary Beard, Washington, D. C., chairman; Miss Marion Howell, Cleveland; Miss Nellie Hawkinson, Chicago; Sister Olivia, Washington, D. C., and Miss Julia Stimson, New York. The need of the armed forces for nurses, the enrollment of nurses by the American Red Cross and the national inventory of nurses were among the many subjects discussed by this subcommittee.

The Health and Medical Committee also requested the National Research Council to establish committees on aviation medicine and neuropsychiatry, as these fields would be more appropriately handled by the Division of Medical Sciences of the National Research Council. These two committees of the

Council were organized in addition to existing committees which had been set up at the request of the Surgeons General to serve in an advisory capacity to the Medical Corps. The Health and Medical Committee has made use of the National Research Council's committees in the special fields of professional advice and research. Funds to enable the Health and Medical Committee to pursue its administrative program and to inaugurate needed investigations were not forthcoming throughout October and November, but the National Defense Advisory Commission loaned funds to the Health and Medical Committee which made it possible for meetings of the subcommittees to be held.

On November 28, 1940, the Council of National Defense designated the Federal Security Administrator, Mr. Paul V. McNutt, as coördinator of all health, medical, welfare, nutritional, recreational and other related fields of activity affecting the national defense. The Health and Medical Committee was transferred at this time to the Federal Security Agency and "shall hereafter exercise its duties and functions under the direction and supervision of the Federal Security Administrator." The following day Mr. McNutt wrote to the Director of the Bureau of the Budget requesting that \$250,000 be made available as soon as possible for the operation of the committee and that a hearing for the purpose of reviewing the operations of the committee and providing additional allocations, if necessary, be granted on or about March 1, 1941. This request for funds was promptly granted.

The Health and Medical Committee at its later meetings has considered various recommendations and communications and has forwarded some of them to the Federal Security Administrator for presentation to the Council of National Defense.

Selective Service Deferment of Medical Students Urgent

At a joint conference which included the Committee on Medical Preparedness of the American Medical Association, the Subcommittee on Medical Education of the Health and Medical Committee of the (National) Coördinator for Health and Welfare, and the Council on Medical Education and

Hospitals of the American Medical Association, which was held in the headquarters of the American Medical Association in Chicago on February 15, it was determined, after extended discussion, to send the following telegram at once to Mr. Clarence A. Dykstra, Director of the Selective Service System, in Washington, D. C.:

"1. Since the five year preparedness program of the government will require about three thousand five hundred medical graduates annually to enter the service of the Army, Navy and Public Health Service for a year's training, the education of physicians must be continued at the present level and without interruption.

"2. This is so vital to military and general welfare that we urge the Director of Selective Service to make clear to draft and appeal boards that it is in the interest of the country to provide deferment of military service for students in good standing in approved medical schools who may be called for duty under the Selective Service Act until they shall have obtained the degree of doctor of medicine. The Committee on Medical Preparedness of the American Medical Association offers its facilities for the verification of the credentials and such other information as may be needed in connection with the application of any medical student for deferment.

"3. In order to provide a continuing supply of qualified medical students for the medical schools of this country, we urge also that students who have been accepted for admission to approved medical schools in a period not to exceed twelve months preceding enrollment be granted deferment of military training in order that they may complete the requirement for admission to medical schools.

"4. Suggestions that the number of medical students be increased can have no relationship whatever to the situation now confronting us because such an increase in the number of students admitted to medical schools during the current year could not in any way affect the number of doctors available for either military or civilian service before 1946. Such an increase of medical classes would surely tend to lower the quality of instruction and in the end cause a deterioration of medical service."

PROFESSIONAL HEADACHES: — Few medical men can run an office without having an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co., New Haven.

LEGISLATIVE SECTION

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D. C. Y. MOORE
S. Manchester

HARRY B. HANCHETT
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JOSEPH A. BEAUCHEMIN
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Somers

CECIL R. GARCIN
Danielson

JAMES R. MILLER
A.M.A. Delegate

ARTHUR B. LANDRY, President

CREIGHTON BARKER, *Executive Secretary*

The 1941 Birth Control Bills

The birth control bill in the Senate, introduced by Senator Bingham, (D.) of the 20th District

AN ACT CONCERNING PUBLIC HEALTH—S. B. 823

Hospitals or other institutions, receiving state grants, and health institutions supervised by at least five licensed physicians may advise and prescribe for married persons regarding marriage problems and may give them access to medical information and supplies conducive to health, notwithstanding the provisions of sections 6244, 6246 and 6562.

The birth control bill in the House, introduced by Mrs. Arnold, (R.) Westport

AN ACT CONCERNING HEALTH—H. B. 1813

Hospitals or other health institutions receiving state grants and other health institutions under the supervision of practicing physicians may disseminate informations or prescribe contraceptive devices to meet health problems of married women.

Hearings on these bills have been scheduled by the Committee on Public Health and Safety of the House and Senate for 1:30 P.M., Thursday, April 10th, in the Hall of the House.

Federal Legislation

CONNECTICUT REPRESENTATIVES IN THE SEVENTY-SEVENTH UNITED STATES CONGRESS

SENATORS

John A. Danaher Hartford

Room 359, Senate Office Building, Washington

Francis T. Maloney, Meriden

Room 354, Senate Office Building, Washington

CONGRESSMAN-AT-LARGE

Lucien Maciora, New Britain

Room 126, House Office Building, Washington

CONGRESSMEN BY DISTRICTS

Districts

1 Herman P. Kopplemann, Hartford
Room 1620, House Office Building, Washington

2 William J. Fitzgerald, Norwich
Room 208, House Office Building, Washington

3 James A. Shanley, New Haven
Room 1610, House Office Building, Washington

4 Leroy D. Downs, South Norwalk
Room 105, House Office Building, Washington

5 J. Joseph Smith, Waterbury
Room 1406, House Office Building, Washington

The committees of the Senate and House so far have been according priority to measures dealing primarily with the preparedness program and very little consideration has as yet been given to proposals not coming within that category. Senator Wagner has not yet introduced his bill providing for a national health program.

INDUSTRIAL HAZARDS

S. 509, introduced by Senator Murray, Montana, January 23. A Bill To provide for the general welfare by enabling the several States to make more adequate provisions for the control and prevention of industrial conditions hazardous to the health of employees. Referred to the Senate Committee on Education and Labor.

To enable each State to provide more adequate protection to workers and their families from economic losses caused by disability or death resulting from occupational diseases by promoting the prevention and control of industrial conditions hazardous to the health of workers. The Secretary of Labor will be charged with the responsibility of administering this act and all state plans must be approved by that federal official. *A state plan, among other things, must provide for its administration by*

the state labor department or other agency charged with the administration of the general labor laws of the State.

CANCER

H. R. 1007, introduced by Representative Rogers, Massachusetts, January 3. A Bill To Amend the Act approved August 5, 1937, entitled "An Act to provide for, foster, and aid in coördinating research relating to cancer; to establish the National Cancer Institute; and for other purposes." Referred to the House Committee on Interstate and Foreign Commerce.

The bill proposes a federal appropriation for the first year of its operation of \$2,300,000 and thereafter such sums as may be necessary to enable the Public Health Service to assist States, counties, cities, or other political subdivisions of the States to extend and improve measures through public and private institutions and organizations for the diagnosis, treatment and control of cancer, including the provision of hospital, diagnostic, clinic, and other facilities for the diagnosis and treatment of persons suffering from cancer or suspected of suffering from this disease. State plans, to be approved by the Public Health Service, must among other things provide for the coöperation of the "appropriate professional groups" and for improving and extending the facilities necessary for diagnosis and treatment of cancer in which preference will be given to the treatment of needy persons.

HOSPITALS

H. R. 584, introduced by Representative Fulmer, South Carolina, January 3. A Bill To promote the national health and welfare through appropriation of funds for the construction of hospitals. Referred to the House Committee on Interstate and Foreign Commerce.

This bill is identical with the Wagner-George hospital construction bill as it was introduced in the Seventy-sixth Congress. It will be recalled that the Senate Committee on Education and Labor rewrote S. 3230, reported it favorably to the Senate and that thereafter the Senate passed the bill in an amended form. In the House, it was referred to the House Committee on Interstate and Foreign Commerce where it died when the Congress automatically expired.

CABINET OFFICER FOR HEALTH

H. R. 1791 introduced by Representative Pfeifer, New York, January 10. A Bill To establish a Department of Health. Referred to the House Committee on Expenditures in the Executive Departments.

This bill proposes to establish at the seat of government an executive department to be known as the Department of Health at the head of which is to be a Secretary of Health, "a member of the medical profession." There will be transferred to this department, if the bill be enacted, the Food and Drug Administration, the Bureau of the Census, Division of Vital Statistics, the Freedmen's Hospital and St. Elizabeths Hospital, the Children's Bureau, and all functions of the United States Public Health Service, Bureau of Narcotics, and the Health Department of the District of Columbia. The President will be authorized by executive order to transfer to this department at any time within ninety days after the passage of the act the whole or any part of bureau, service, or other agency of the government primarily engaged in fostering and promoting health and sanitation.

CHIROPRACTORS

H. R. 1052, introduced by Representative Tolan, California, January 3. A Bill To amend section 40 of the United States Employees' Compensation Act, as amended. Referred to the House Committee on the Judiciary.

The purpose of this bill is to give to chiropractors the right to treat injured federal employees entitled to the benefits of the United States Employees' Compensation Act. It is identical with a bill introduced by Representative Tolan in the Seventy-sixth Congress. A subcommittee of the House Committee on the Judiciary held a hearing on the previous bill but took no further action with respect to it.

HEALTH INSURANCE

S. 489, introduced by Senator Capper, Kansas, January 23. A Bill To aid in the establishment and administration of State health insurance plans. Referred to the Senate Committee on Education and Labor.

This is the perennial health insurance bill sponsored by the American Association for Social Secur-

ity. It proposes a federal appropriation of \$50,000,000 for the fiscal year ending June 30, 1941, and thereafter annually a sum sufficient to carry out the purposes of the act, to induce States to embark on a combined program of compulsory and voluntary health insurance. The bill proposes to engraft the scheme onto the Social Security Act and the Social Security Board will be charged with the duty of approving state plans. Local councils, it is proposed, will prepare and publish lists of general medical and dental specialists, nurses, groups of such practitioners, pharmacists, hospitals, clinics, laboratories, and other persons and agencies who have agreed or with whom arrangements have been made to furnish the medical benefits and will distribute on a "pro rata basis" among the several practitioners or groups of such practitioners who have agreed to furnish the medical benefits those entitled to such benefits who after due notice have failed to make a selection or who have been refused by the practitioner or group of practitioners whom they have selected. Such local councils, too, will fix the method by which practitioners and others furnishing the medical benefits may be paid. Every general medical and dental practitioner, duly licensed to practice in the State "without discrimination against any school or mode of practice which is lawful in the State" and any group of such practitioners, the bill provides, shall have the right to be included in the list of those furnishing the medical benefits.

TUBERCULOSIS

H. R. 70, introduced by Representative Elliott, California, January 3. A Bill To promote the national health through the prevention and control of tuberculosis among migrants, and for other purposes. Referred to the House Committee on Interstate and Foreign Commerce.

The Surgeon General of the Public Health Service will administer the provisions of the bill and all state plans must be approved by that official.

HANDICAPPED CHILDREN

H. R. 958, introduced by Representative Angell, Oregon, and H. R. 1825, introduced by Representative Boland, Pennsylvania, January 3 and January 10, respectively. A Bill To provide for the education of all types of physically handicapped children, to make an appropriation of money therefor, and to regulate its expenditure. Referred to the House Committee on Education.

For each fiscal year this bill proposes a federal appropriation of \$11,580,000 to enable each State to establish, extend and improve services for educating children who are crippled, blind, partially seeing, deaf, hard of hearing, defective in speech, cardiopathic, tuberculous, or otherwise physically handicapped, and who for their education require an expenditure of money in excess of the cost of educating physically normal children. A state plan must be approved by the Commissioner of Education of the United States and must provide for its administration by the state department of education or public instruction.

TUBERCULOSIS

S. 195, introduced by Senator Murray, Montana, January 6. A Bill To impose additional duties upon the United States Public Health Service in connection with the investigation, treatment, and control of tuberculosis. Referred to the Senate Committee on Finance.

To aid States, counties, cities, health districts, and other political subdivisions of States, including the District of Columbia, Alaska, Puerto Rico, Virgin Islands, and Hawaii to establish, extend and improve measures for the prevention, treatment, and control of tuberculosis, including the provision of facilities for sanatorium and other care for persons with tuberculosis and for the making of studies, investigations, and demonstrations to develop more effective measures of prevention, treatment, and control of tuberculosis.

SOCIAL SECURITY

S. 670, introduced by Senator Walsh, Massachusetts, January 29. A Bill To extend the Federal old-age and survivors insurance benefits of the Social Security Act to certain employees of religious and charitable organizations. Pending in the Senate Committee on Finance.

The purpose of this bill is to bring within the old-age and survivors insurance benefits provisions of the Social Security Act employees of any corporation, community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes, or for the prevention of cruelty to children or animals.

PHYSICALLY HANDICAPPED PERSONS

H. R. 2818, introduced by Representative Knutson, Minnesota, January 29. A Bill To amend the

Social Security Act by providing for grants to States for furnishing aid to needy individuals who are physically handicapped. Pending in the House Committee on Ways and Means.

This bill contemplates a federal appropriation of \$10,000,000 for the first year and thereafter such a sum as may be necessary to enable the States to furnish money payments to physically handicapped individuals.

TUBERCULOSIS HOSPITALS

H. R. 3463, introduced by Representative Voorhis, California, February 18. A Bill To promote the national health and welfare through appropriation for hospitals and for the prevention, education, and control of tuberculosis. Pending in the House Committee on Interstate and Foreign Commerce.

For the fiscal year ending June 30, 1941, the bill proposes a federal appropriation of \$25,000,000, for the fiscal year ending June 30, 1942, \$50,000,000, and for each of the ten fiscal years thereafter the sum of \$100,000,000 from which to make loans to States, counties, cities and other political subdivisions for the construction of tuberculosis hospitals and for their maintenance for a period of not over four years.

In addition, for the fiscal year ending June 30, 1941, an appropriation of \$3,000,000 would be authorized, for the fiscal year ending June 30, 1942, an appropriation of \$5,000,000, and for each of the ten fiscal years thereafter an appropriation of \$10,000,000 a year for grants-in-aid in the prevention and control of tuberculosis. Free diagnostic and treatment facilities, it is contemplated, shall be provided by all health departments or clinics receiving funds under the act (1) for the diagnosis and emergency treatment of any patient referred by a private physician either for continued treatment or for consultive or diagnostic advice and opinion and (2) for any patient unable to afford private medical care. The determination of the ability of patients to pay for medical care will be the responsibility of the director of the health department or clinic in conjunction with a committee from the local medical societies. If and when tuberculosis ceases to be a national health problem, such physical equipment and facilities as the Federal Government may have acquired by virtue of the operation of this bill will

thereafter be utilized in the control of cancer or other major health hazards.

DRUG ADDICTION

H. J. Res. 99, introduced by Representative Coffee, Washington, January 30. A Joint Resolution to provide for a survey of the narcotic-drug conditions in the United States by the United States Public Health Service. Pending in the House Committee on Interstate and Foreign Commerce.

This Joint Resolution proposes to direct the Surgeon General of the Public Health Service to make investigations to obtain information as to (1) the extent of unlawful activities with respect to narcotics, and the number of persons connected with such activities; (2) the extent of addiction to the use of narcotics in the several States and Territories, the number of addicts therein, the causes of addiction, the availability and use of various kinds of treatment, and other related matters; and (3) the conditions and trends with respect to the prevalence of evils arising from narcotics. The purpose of this investigation, the resolution states, is to aid Congress to enact laws properly to protect the people.

PUBLIC HEALTH

H. R. 3204, reported from the House Committee on Appropriations by Representative Taylor, Colorado, February 10. A bill making additional appropriations for the fiscal year 1941 urgently required for the Work Projects Administration and certain other federal agencies. Passed by the House and Senate.

One section of this bill proposes a federal appropriation of \$525,000 for the fiscal year ending June 30, 1941, to enable the United States Public Health Service to assist state and local health authorities in health and sanitation activities in (1) areas adjoining military and naval reservations; (2) areas where there are concentrations of military and naval forces; (3) areas adjoining government and private industrial plants engaged in defense work; and (4) private industrial plants engaged in defense work. The money will be available, too, to provide emergency health and sanitation services in government industrial plants engaged in defense work and in areas adjoining military and naval reservations outside of the United States.

THE FORUM

Douglass, Professor of Obstetrics at the University of Maryland Medical School, presented his views on the Toxemias of Pregnancy to the 9th Annual Postgraduate Clinic held at the George Washington University Medical School in February, 1941. His comments on treatment are noteworthy. Hyperemesis Gravidarum (Pernicious Vomiting of Pregnancy) is a purely psychogenic disorder and the symptoms it presents are a direct result of tissue starvation and dehydration. Recommended treatment is psychiatric and symptomatic. Judicious search will usually unearth the exciting psychic factor. Active measures include rest, sedation, small frequent feedings, fluids and plasma intravenously and daily injections of 50-75 mgms. of Vitamin B₁. Therapeutic abortion is a last ditch procedure and he specifically warns against mentioning its advisability to the patient. So doing only intensifies the neurosis and makes the intervention mandatory. In amplifying this statement he cited a series of cases that stopped vomiting promptly following "simulated" abortions—technique and suggestions for the explanatory verbal by-play may be had by writing *The Forum* editor. The pre-eclampsias and eclampsia give ample warning. A significant rise in both systolic and diastolic pressures is a constant sign and may be the only one. This and the other prodromal symptoms can be detected if the patient receives adequate prenatal care. Recommended treatment of the pre-eclampsias consists of rest, sedation, adequate diet and intravenous 10% glucose as these patients exhibit a low blood sugar. If the patient improves the pregnancy may be allowed to continue under close supervision. However, it must be terminated if the symptoms recur.

The incidence of eclampsia has been reduced, but a further improvement is to be desired since this complication is almost wholly preventable. Most

cases occur in women who have had no prenatal care. Others occur either because the patient fails to report symptoms early enough or because the attending doctor misinterprets the significant items.

Treatment should be carried out in a hospital and special nursing care provided. No morphine is used; sedation is accomplished by rectal instillation of 30 to 50 cc. of paraldehyde, repeating it as needed. In urgent cases 10 to 15 cc. may be given intravenously. Fluid balance is maintained by clyses and intravenous 10% glucose. Labor is induced as soon as possible. If time permits, medical induction, rupture of the membranes, or bagging are the procedures of choice. If the case is urgent Cesarean section should be done. During the past two years he and his staff treated 35 cases by this method with only one death and that one excusable since the patient was moribund when admitted to the hospital.

While in Washington, we stopped in to see Doctor Paul Dickens, director of the Cecelia Cummings (Homer S. Cummings) fund for research on essential hypertension. Although he had little that is new to offer, what he had to say was interesting. In the first place he confirmed the value of our present treatment regime: periodic rest and graduated exercises, mild sedation, curtailment of activity, psychological readjustment, reduction of overweight and endocrine therapy when indicated. Nitrates are still the most dependable drugs to use. Potassium thiocyanate may be of value in special cases but blood levels must be checked. From certain animal experiments with diminished renal circulation they have confirmed its influence on pressure, and surgeons have devised and performed operations to increase this circulation. The early reports are very favorable. The final item was about a depressor substance derived from the kidney. Although the quantity of this factor has been very limited, the results they have secured with it promise well for the future.

T. P. R., M.D.

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LETTERS TO THE EDITOR

The Need for a General Practitioners' Section in The Connecticut State Medical Society

To the Editor:—

The admirable policies of the American Medical Association in establishment of strict requirements for training of internes and residents in approved hospitals have given rise to an unfortunate situation for general practitioners. These policies are to be found in the *JOURNAL*, August 26, 1939, pages 794-799, "Essentials of Approved Residencies and Fellowships." Because of these requirements the general practitioner now finds himself in a position wherein he no longer is shown the courtesy of hospital privileges, since only specialists can qualify for privileges on approved services. His position is further restricted by the policies emanating from the specialty boards. The latter, through their power in the various sections of the state and in the national medical societies, as well as in the hospitals, determine at present the policies of the hospitals and the medical societies. By so doing, they define the place of the general practitioners in their work.

In view of this situation, the general practitioners in New Haven, following the example set by similar groups in Westchester County, New York, and in Wayne County, Michigan, have under consideration a section for general practitioners in the Connecticut State Medical Society. This was undertaken with the approval of the State Medical Society and with the coöperation of the Secretary of the Society. A committee has been appointed by Doctor Barker and includes the following: Dr. Charles Carrodino, Temporary Chairman, Doctor Hermann S. Cutler, Temporary Secretary, and Doctors Robert Taylor, Michael Shea, Edmund FitzSimmons, Robert Tracy and William Powell. It should be emphasized that these men are serving only in a temporary capacity. It is the desire of the New Haven group that the section be established on a permanent basis at the forthcoming annual meeting of the Connecticut State Medical Society to be held in Bridgeport in May of this year.

The New Haven group has proposed definite objectives, formulated upon the objectives of the

already established general practitioners' sections in other parts of the country.

The objectives of the New Haven group follow:—

1. To assist and further the position of the general practitioner in his community.
2. To clarify the relationship of the general practitioner to hospital staffs.
3. To encourage closer participation and more proportional representation in the activities of the local and state medical societies.
4. To present clinical programs of interest to practitioners of general medicine at state and local society meetings.
5. To encourage general practitioners to participate in post-graduate study.

The importance of the general practitioner in medicine needs no emphasis. The recent articles by Doctor Davison and the abstract of an article by Doctor Simmons in the *Journal of the A. M. A.* of December 21, 1940, define his position very clearly. "The general practitioner's close associations with his patients, his sincere understanding of their immediate illness and their medical and social background is well known. These permit him to treat his patients from a deeply personal point of view; the patient becomes not just another case but an individual whose problems are intimately known to his physician."

There is a crying need for more general practitioners. The public needs and wants more general practitioners, because he successfully treats over 80% of disease. However, 75% of the present graduates are, or plan to be, specialists, who are needed by less than 20% of the patients. Young graduates, as well as laymen, share the erroneous idea that the same dignity is not commanded by general medicine as by a specialty. With the creation of the specialty boards there arose the impression that general medicine is what the specialist discarded. We must remedy this situation.

The general practitioner sees the vast majority of sick people. In most instances it is he who refers them to a specialist. The general practitioner then becomes not only the alleviator of most illnesses but the intelligent and understanding intermediary between the specialist and the patient. Yet at present, due to a very unfortunate situation, the general practitioner finds himself cut off from his patient when hospitalization is required.

With the present trend the general practitioner will no longer do minor surgery, obstetrics, gynecology, or pediatrics, once his patient is admitted to a hospital. The patient under such a system will have to be turned over to the specialist for treatment. This is undesirable to the patient, unfair to the general practitioner, and extremely embarrassing to the specialist and hospital authorities. The patient once hospitalized can no longer see the doctor of choice but must be treated by the physicians on the hospital service or a specialist recommended by the patient's personal physician. The hospital authorities under the present system must necessarily refuse their hospital's facilities to the general practitioner. The evils and complications of such a situation are apparent to all of us. Something should be done to alleviate them and to bring them to the attention of our colleagues. It is the desire of the recently formed group in New Haven to take the initiative in this matter.

It is the feeling of this group that an organization founded on the objectives enumerated above, and intimately associated with the other sections of the state and local medical societies, would be in a better position to familiarize the governing boards of hospitals and the specialties with their problems than would individual appeals made by various members of an unorganized group of physicians.

Such a section of general practitioners would necessarily be asked to send representatives to medical meetings and to elect members to the local and state medical boards. The hospital authorities, whose institutions largely depend upon monies received from patients hospitalized by general practitioners, could consult representatives of the general practitioners' organization regarding policies of the hospitals.

It probably was in reference to such a plan of readjustment that Sir William Osler would again say as he did at the Centennial Celebration of the New Haven Medical Association, January 6, 1903: "Unity and friendship! How we all long for them, but how difficult to attain!" "Strife seems rather to be the very life of the practitioner, whose warfare is incessant against disease and against ignorance and prejudice, and, sad to have to admit, he too often lets his angry passions rise against his professional brother. The quarrels of doctors make a pretty chapter in the history of medicine. Each generation seems to have had its own. In too many towns and smaller communities, miserable frictions prevail, and

bickerings and jealousies mar the dignity and usefulness of the profession. So far as my observation goes, the fault lies with the older man. The young fellow, if handled right and made to feel that he is welcomed, is only too ready to hold out the hand of fellowship.

"The society comes in here as a professional cement. The meetings in a good friendly social way lead to a free and open discussion of differences in a spirit that refuses to recognize differences of opinion on the non-essentials of life as a cause of personal animosity or ill feeling."

"There is no room for envy, hatred, malice or any uncharitableness." "The well conducted medical society should represent a clearing house, in which every physician of the district would receive his intellectual rating and in which he could find out his professional assets and liabilities."

The general practitioner must have hospitals, medical societies and organizations where mutual problems are discussed and solved. An organization meeting is to be held during the Annual Meeting of the State Society in Bridgeport in May of this year. Those who desire membership in the section are urged to apply to the Temporary Secretary, Hermann S. Cutler, 425 Forbes Avenue, New Haven, Connecticut, or to the Connecticut State Medical Society, 258 Church Street, New Haven, Connecticut.

Hermann S. Cutler, M.D.

NEWS

from County Associations

Fairfield

Doctor James E. Crane of Stamford is now stationed at Fort Benning, Georgia, where he is serving as a First Lieutenant, Medical Corps, attached to the Officers Training Center.

The new format of the State Journal has received wide approval. Particular commendation has been expressed by those who have examined the details of type and set up.

Fairfield County will be host to the State Medical Association at their 149th annual meeting to be held at the Stratfield Hotel, Bridgeport, May 21 and 22. The local committee on general arrangements which

will later be enlarged now consists of Doctors Stanton Smith, chairman, Crawford Griswold and D. B. Hardenbergh. Any group wishing to hold its own meeting in conjunction with the state meeting is requested to communicate with this committee at once.

The county committee for new members, Doctors James D. Gold and J. Grady Booe, are contacting every eligible physician in the county in an effort to get a full membership list.

The regular monthly meeting of the Stamford Hospital was addressed by Doctor Gray Twombly of Memorial Hospital, New York, on the subject: "Relations between Hormones and Cancer." On March 4 the Bridgeport Medical Association was addressed by Doctor Lawrence H. Cotter, attending physician at the Presbyterian Hospital and the Vanderbilt Clinic, on the subject: "The Significance of Blood Findings in the Practice of Clinical Medicine."

At the recent meeting of the Stamford Lions Club, Doctor E. Cotten Rawls of the surgical staff at Stamford Hospital gave a short talk on "Recent Advances in Surgery."

Hartford

Doctor W. O. Abbott of Philadelphia gave a splendid Clinic at St. Francis Hospital on March 3, from 5:00 to 6:00 o'clock at which time he spoke about fluid balance, vitamin feeding, electrolitical balance, etc., his remarks being occasioned by a presentation of a small bowel fistula which had been successfully operated on. In the evening at the Hartford Medical Society Doctor Abbott described the use and abuse, indications and contra-indications for the tube which he, in conjunction with Doctor T. Grier Miller of Philadelphia, devised. Interesting slides to emphasize his remarks were shown and the discussion and question period following the main discourse brought out further important facts regarding this valuable apparatus known as the Miller-Abbott Tube.

Members on full time active military service are exempt from dues for each year or part of the year, and dues for that year, if already paid, are to be remitted. This was voted by the Board of Directors at its meeting held on February 19.

Doctor W. T. Morrissey, President of the Hartford County Medical Association has appointed Doctor B. B. Robbins of Bristol to the Committee on Public Policy and Legislation to serve the bal-

ance of the unexpired term of the late Doctor R. A. Outerson.

Doctor Benjamin L. Salvin of Hartford has been certified as a Diplomate of the American Board of Urology.

Litchfield

Doctor Elias Pratt, Health Officer of Torrington, was recently discharged from the Charlotte Hungerford Hospital where he went through a rather serious operation. He is reported as convalescing comfortably at his home.

Doctor Frank L. Polito has been appointed as physician to the Police and Fire Departments by Mayor William Patten. Doctor Polito succeeds the late Doctor Timothy M. Ryan.

During the absence of Doctor Elias Pratt from his duties as Health Officer, Doctor Andrew Orłowski, Assistant Health Officer, has been acting in his stead.

Doctor Fernand M. Riendeau announces the opening of an office at 30 Mason Street for the practice of medicine. Doctor Riendeau is a graduate of the University of Paris—and had his internship at the American Hospital at Nieully, France. He spent one year at Brattleboro, Vt., hospital and for 12 years was a physician at the Norwich State Hospital. He resigned a short time ago and since that time has been studying at the New York Postgraduate Clinics. Doctor Riendeau received his undergraduate education at Assumption college, Worcester, Mass. He is the husband of Doctor Pauline Riendeau who recently opened an office at 30 Mason Street, specializing in women's diseases.

On Wednesday, February 12, the regular monthly meeting of the Staff was held at the Charlotte Hungerford Hospital under the Chairmanship of the Chief, Doctor Harry B. Hanchett. Following a discussion of case records, there was a general discussion of staff organization, promotions, etc.

On Thursday, February 13, the regular meeting of the Journal Club of the Charlotte Hungerford Hospital was held in the Staff room. The following films were shown:

1. Vaginal repair of cystocele and rectocele.
2. Transverse cervical Caesarean section.
3. Latzko extra-peritoneal Caesarean section.

Special Notice: The next meeting of the Association of Connecticut Tumor Clinics will be held in the Charlotte Hungerford Hospital, Torrington, on

Thursday, April 10, at 4:00 P. M. The program will be:

Carcinoma of the Mouth—Emerson S. Hill.

Carcinoma of the Cervix and Uterus—Floyd A. Weed.

Early Carcinoma of the Cervix—Paul A. Younge.

Discussion is to be opened by Doctor George Smith. Supper will be served at the hospital on completion of the program. All physicians in the State are invited to attend this meeting.

The regular monthly tumor conference was held in the Staff room of the Charlotte Hungerford Hospital on March 5. Doctor Douglas J. Roberts of Hartford presented several cases and discussed the subject of "Malignant Bone Tumors."

On Wednesday evening, March 5, the Torrington Medical Society was entertained by an interesting and instructive lecture on the subject of "Mechanical Hearing Aids." The lecturer, Mr. Joseph Newbury, of Torrington, illustrated his talk with sound motion pictures.

Captain William C. Kennedy, member of the local National Guard Unit and recently inducted into service with the regular army, left to assume his duties at Camp Blanding, Florida, on March 13.

Doctor and Mrs. Floyd A. Weed have just returned from a short vacation in Florida.

Doctor Albert W. Buck, Director of the Charlotte Hungerford Hospital, has recently returned from Boston where he attended the meetings of the New England Hospital Assembly.

Middlesex

At the annual meeting of the Central Medical Society held recently at Bengston-Wood Hall the following officers were elected: President, Philip E. Schwartz; Vice-President, Harry S. Whiting; Secretary, Hazen A. Calhoun; Treasurer, Henry Sherwood.

Doctor A. N. Creadick of New Haven addressed the Society on the subject of "Hormones in Gynecology."

Because of a larger number of examinations than previously anticipated, the medical board of the local draft office has formed an auxiliary group composed of Doctors Richard Grant, Lloyd Minor and Henry Sherwood who will aid in the work of examining and classifying the selective service draftees.

Doctor Lyle A. Baker, Cardiologist at the U. S. Veterans Administration Facility, San Francisco,

California, and at present assistant in medicine at the Massachusetts General Hospital, Boston, Massachusetts, will address the annual meeting of the Middlesex County Medical Society on April 10. His subject will be "The Changing Concept of Hypertension."

New Haven

Doctor Clifford Kuh, Chairman of the Committee on Industrial Health, Connecticut State Medical Society, presents the chief views and developments of the nation's industrial health leaders in "Connecticut Industry" for February, 1941. The article is a resume of the Third Annual Congress on Industrial Health held in Chicago, January 13-15, 1941.

Doctor Simon B. Kleiner of New Haven addressed a joint meeting of the Proctologic Society of the University of Pennsylvania Graduate Hospital and the New York Proctologic Society on March 19 at Philadelphia. His subject was "Some Orthopedic Problems in Proctology."

New London

The Norwich Free Academy is sponsoring a series of health talks for students and members of the community in the interest of public health and preventive medicine. Each Sunday afternoon at four o'clock in Slater Memorial Hall some specific medical subject of interest to the public is being presented by a local leader in that field. During March Pneumonia, Mental Hygiene, Cancer, Appendicitis, and Your Family's Food and Health have been discussed by Doctors Maurice Moore, William A. Bryan, Robert Agnew, David Sussler, and Margaret S. Chaney, respectively. The program for April follows:

April 6—Doctor Hugh B. Campbell—"Tuberculosis."

April 20—Doctor Lewis Sears—"Heart Disease."

April 27—Doctor Louis H. Cohen—"Psychology of Good Health."

The monthly meeting of the New London County Medical Association was held at Uncas-on-the-Thames, March 6, at 8:30 P. M. Doctor Andrew Marchetti of the New York Lying-In Hospital spoke on "The Toxemias of Pregnancy." It was the first paper on an obstetrical subject presented to the Society for several years. For that reason this timely presentation was well received.

Doctor Shirley Baron, visiting Otorhinolaryngologist at the Lawrence Memorial Hospital, New London, was ordered to active duty as a Captain, U. S. N. M. C. (R), to report March 17, 1941, at the

Submarine Base Hospital, New London.

Doctor Carl Wies of New London, Captain Coast Artillery, U. S. A., (R), was ordered to active duty to report March 10, 1941, at Fort Wright, Fishers Island, N. Y. Doctor Wies is going into the Army as a line officer. He graduated from Yale Medical School in 1932. He graduated from M. I. T. Engineering Department in 1927. While at M. I. T. he was a member of the R. O. T. C.

The annual meeting of the New London County Medical Association with election of officers will be held at the Seaside Sanatorium, Waterford, April 3. Doctor George Cahill, New York City, will speak on "Urinary Infections." The business is scheduled for 4:00 P. M.

The reports of the findings by the physicians of Uncas-on-the-Thames on x-ray of chests in the tuberculosis campaign conducted by the local health department were delivered to the New London physicians and the physicians of the suburbs last week. Five cases needing sanatorium treatment were discovered. Two of these cases appear to have been unknown to the physician and patient before the x-ray examination. One case was a male in the 26-30 age group, the other case a female in the 31-35 age group. In a number of cases tuberculin tests were recommended. Several cases of heart abnormalities were discovered that appeared to have been unknown to the patient and physician before x-ray examination.

News from Yale University School of Medicine

Doctor Francis G. Blake, who has been Acting Dean of the medical school, has accepted the appointment of Dean. Doctor Blake will continue as Professor of Medicine and Physician-in-Chief of the New Haven Hospital.

Doctor William T. Salter, an associate of the Thorndike Memorial Laboratory of the Boston City Hospital, has been appointed Professor of Pharmacology.

Doctor Milton C. Winternitz spoke on "The Yale School of Medicine in Wartime" to a gathering of Yale Alumni on Alumni University Day, February 22.

Doctor C. E.-A. Winslow, Professor of Public

Health, addressed a combined Harvard-Yale meeting on The Universities and National Defense. Doctor Winslow spoke on "The Home Defense Front."

Doctor Samuel C. Harvey, Professor of Surgery, addressed the Congress of Medical Education and Licensure in Chicago on February 17 on the subject of "Objectives of Medical Education."

Doctors John C. Leonard, Ashley Oughterson, and Arthur Geiger spoke before the New Haven Medical Association on March 5 in a symposium on Hypertension.

New Sound Film Tells Story of X-rays in Laymen's Language

To be released shortly by the General Electric X-ray Corporation is a new four-reel sound motion picture, "Exploring with X-Rays." The film is strictly educational in nature, having as its purpose the telling of the story of x-rays and their many applications in language easily understandable to people without technical training. Beginning with the discovery in Roentgen's laboratory and his report to the Physical-Medical Society of Wurzburg, the action progresses rapidly through the period of its announcement and early use by pioneering physicians, to illustrations of the medical, dental, veterinary, and industrial applications of x-radiation, and to a simple ABC explanation of the physics of x-ray production by Doctor William D. Coolidge, director of G.E.'s research laboratories and inventor of the hot-cathode x-ray tube which bears his name. The picture was professionally produced by Haig and Francisco, of Chicago, and was photographed under the direction of John J. Boland, of Hollywood. Most of the scenes were filmed on the Selznick-International lot, where "Gone with the Wind" was produced, although a large number were made at locations in hospitals and industrial plants from one coast to the other.

The story is concerned with a young medical student who goes to a radiologist for an x-ray examination of his knee, and stays to learn of the many places in which x-rays have proved of great value, discovering, too, that even the majority of industrial applications are connected rather closely with health and safety. Among the characters in the picture are many whose faces will be familiar to movie-goers—including Richard Webb, Joseph Crehan, June Wilkins, Edwin Stanley, Forrester Harvey, and many others.

Designed principally for exhibition before lay audiences, the film will be loaned free of charge, except for transportation costs, to doctors who are asked to appear before groups such as luncheon clubs, parent-teacher associations, study groups, and technical societies. In order that members of the medical profession and others whose work is closely allied with x-ray may have an opportunity to become acquainted with the contents of the film before it is released generally, "Explorations" will be reserved for a short period for exhibition exclusively before professional society meetings.

A leaflet describing the picture and including instructions for reserving it for exhibition is available from the General Electric X-ray Corporation in Chicago.

SPECIAL NOTICES

CONNECTICUT FRACTURE COMMITTEE MEETING

The Annual Meeting of the Connecticut Fracture Committee of the American College of Surgeons will be held at Hunt Memorial, 36 Prospect St., Hartford, on Thursday, May 1st. The Business Meeting will be held at 10:00 A. M., with reports of the committees, after which there will be a discussion of the military aspects of fracture surgery.

This meeting will be followed by a luncheon for the members and guests at the Hartford Club. There is to be a Scientific Session at 2:00 P. M. at which Doctor Clay Ray Murray of the Presbyterian Hospital, New York will speak on the important subject of fracture healing. This subject will be further discussed by two of the Committee members. One will discuss the general factors in the healing of fractures and the other the local factors involved in the healing of fractures.

This meeting is planned to appeal to the general practitioners of the State as well as those primarily interested in fracture surgery and it is hoped that there will be a large attendance by people who will contribute to the general discussion.

PRELIMINARY PROGRAM

NURSING INSTITUTES ON POLIOMYELITIS CONNECTICUT STATE DEPARTMENT OF HEALTH

Bridgeport, Connecticut

Monday, April 14th, 1941
Burroughs Library

Hartford, Connecticut

Tuesday, April 15th, 1941
St. Francis Hospital

Norwich, Connecticut

Wednesday, April 16th, 1941
William W. Backus Hospital

Registration (no fee)

Afternoon Session (2:00 P. M.)

Epidemiological and Medical Aspects of Poliomyelitis.

JAMES D. TRASK, M.D., Associate Professor of Pediatrics,
Yale University School of Medicine.

(To speak at Bridgeport and Hartford sessions.)

EUGENE LAMOUREAUX, M.D., Epidemiologist, Bureau of
Preventable Diseases, Connecticut State Department of
Health.

(To speak at Norwich session.)

Orthopedic Aspects of Poliomyelitis

PAUL P. SWETT, M.D., Consultant in Orthopedics to the
Hartford Hospital, Newington Home for Crippled Children
and Neuro-Psychiatric Hospital and Institute.

Nursing Care in Poliomyelitis (with demonstrations).

KATHERINE ALLEN, R.N., Consultant in Public Health
Nursing, Crippled Children's Division, Department of
Health of New York City and Instructor in Nursing
Education, Teachers College, Columbia University.

Evening Session (7:30 P. M.)

The Principles of Physical Therapy in the Treatment of
Poliomyelitis.

MURIEL C. DOWNER, M.D., Instructor in Physical Ther-
apy, Yale University School of Medicine.

The Nurse and Physical Therapy.

KATHERINE ALLEN, R.N., Consultant in Public Health
Nursing, Crippled Children's Division, Department of
Health of New York City and Instructor in Nursing
Education, Teachers College, Columbia University.

Motion Pictures Showing the Care of Poliomyelitis.

Exhibits

LECTURES ON INFANTILE PARALYSIS

In April a series of six lectures on Infantile Paralysis by outstanding medical authorities will be presented at Vanderbilt University, Nashville, Tennessee. These lectures are sponsored by the National Foundation for Infantile Paralysis.

Doctor Ernest W. Goodpasture, head of the Department of Pathology at Vanderbilt is supervising the arrangements.

The schedule is as follows:

Monday, April 7th. The History of Poliomyelitis. (Progress of the knowledge of the disease up to the present.)

DOCTOR PAUL F. CLARK, Professor of Bacteriology,
University of Wisconsin School of Medicine.

Tuesday, April 8th. The Etiology of Poliomyelitis. (Including its relation to diagnosis.)

DOCTOR CHARLES ARMSTRONG, Senior Surgeon, U. S.
Public Health Service.

Wednesday, April 9th. Immunity to Poliomyelitis. (Including Serum, Therapy and Vaccination.)

DOCTOR THOMAS M. RIVERS, Director, Hospital of
the Rockefeller Institute for Medical Research.

Monday, April 14th. Pathology and Pathogenesis of Poliomyelitis.

DOCTOR ERNEST W. GOODPASTURE, Professor of
Pathology, Vanderbilt University School of
Medicine.

Tuesday, April 15th. Epidemiology of Poliomyelitis.

DOCTOR JOHN R. PAUL, Yale University School of
Medicine.

Wednesday, April 16th. Treatment and Rehabilitation of
Poliomyelitis Patients.

DOCTOR FRANK OBER, Assistant Dean, Harvard Uni-
versity Medical School.

The lectures will be held in the amphitheatre of the Vanderbilt Medical School at 8 o'clock each evening, and are open to all interested persons. Invitations are being issued to the faculties of various universities, members of medical associations, and others.

The lectures will be so designed and prepared that they will serve as the material for a publication by the National Foundation, intended to constitute a recent survey of the field of Infantile Paralysis. They will also compose a critical review, with bibliography that should be useful as a stimulating educational production, as well as a work of reference for those contemplating or engaged in any investigative work.

SCIENTIFIC SESSION OF THE AMERICAN ACADEMY OF PHYSICAL MEDICINE

The American Academy of Physical Medicine will hold its Nineteenth Annual Meeting and Scientific Session on April 28, 29, 30, 1941, in New York, with headquarters at the Hotel Pennsylvania, where lectures, symposia, clinical papers, motion pictures, and the exhibits will be presented. Clinics will be held at the Medical Center, New York Orthopaedic Hospital, Post Graduate Hospital, and the Skin and Cancer Hospital. There will be an evening session at the Academy of Medicine Building and a banquet at the Hotel Pennsylvania.

Physical medicine in relation to general medicine and the specialties will be the underlying theme of the topics under discussion. These include new developments in electrotherapy, electrosurgery, radiation therapy, hydrology, physical education, military medicine, aviation medicine, and laboratory reports on related investigation.

The sessions are under the direction of Harold D. Corbusier, M.D., Plainfield, N. J., President; Herman A. Osgood, M.D., Boston, Secretary; Fred H. Albce, M.D., New York, Chairman of the Committee on Arrangements; William D. McFee, M.D., Boston, Chairman of the Committee on Program; William Benham Snow, M.D., New York, Chairman of the Committee on Clinics; Franklin P. Lowry, M.D., Newton, Mass., Chairman of the Committee on Exhibits, and Robert S. Harris, Ph.D., Cambridge, Mass., Chairman of the Committee on Research.

All members of the medical profession and those of related interests are invited to attend the scientific program. There will be no registration fee. Address inquiries to Herman A. Osgood, M.D., Secretary, 144 Commonwealth Avenue, Boston, Massachusetts.

INSTITUTE OF INDUSTRIAL MEDICINE AND INDUSTRIAL HYGIENE

A "post graduate" Institute of Industrial Medicine and Industrial Hygiene, attracting industrial health specialists from all parts of North and South America, will be held in Pittsburgh, May 5 to 9. Scores of pertinent papers and discussions are scheduled on the medical and engineering phases of employee health protection.

The Institute marks the 26th annual meeting of the American Association of Industrial Physicians and Surgeons, and the second annual meeting of the American Industrial Hygiene Association. Majority of the sessions will be held at Pittsburgh's William Penn Hotel.

A series of important dry clinics in Industrial Medicine and Surgery will be held at Mercy Hospital on the first day, Monday, May 5th. John P. Griffith, M.D., chairman of the hospital clinic committee and professor of surgery, School of Medicine, University of Pittsburgh, will be in charge.

One of the highlights of the day will be a consideration of diagnosis and treatment of various "Industrial Backs"; another will be a discussion of pneumonia and its treatment with special reference to the use of some of the newer drugs, such as sulphathiazol.

Tuesday, May 6th, will be taken up with a discussion of the following subjects:—"Practical Results of Periodic Physical Examination", "Relation of Trauma to Disease", "Contact Dermatoses", "Sequelae of Head Injuries", "Mental Hygiene in Industry", and "Evaluation of Circulatory Function in Extremities."

Wednesday morning will be devoted to recent research on such subjects as carbon monoxide poisoning; effects of radiation from an ophthalmologic viewpoint; and various aspects of industrial lead exposures and industrial lead poisoning.

Tuberculosis problems will be the main topic of discussion on Wednesday afternoon, including engineering preventive methods in the control of tuberculosis; other methods of prevention and control; and also discussions of bacteria in the air and problems of disinfection and ventilation.

Industrial ventilation problems will be considered on Thursday morning. Subjects to be discussed are: control of gases, vapors and fumes; electroplating operations; air borne infections; radiant cooling; and also studies of recent dust determination methods including concentration and free silica content.

Industrial hygiene dust studies are scheduled for Thursday afternoon. This will include investigations in the chrome brick industry; lead and zinc mining, copper refining; and Fullers Earth as a cause of pneumoconiosis. Papers will also be read on particle sizes of dusts as found in various industries; animal and petrographic studies on talc dusts; and silicosis among naval foundry men.

Thursday evening's session includes miscellaneous subjects: a review of industrial hygiene progress during 1940; claims of industrial poisoning; medicine and engineering evaluation of exposures in the synthetic sausage and casing industry; sampling and determination of aldehydes; and the absorption and elimination of noxious vapors.

Friday's morning session includes a report on dermatitis control in a mass production industry; sporotrichosis as an occupational disease among florists; common solvent exposures; electric arc welding; gases, fumes and vapors from coated welding rods; trends in occupational disease; and eye protection in industry.

The Institute concludes its symposiums on Friday afternoon with discussions of the following subjects: controlled radium hazards; phosphorous toxicology; biochemistry of

carbon bisulfide; new synthetic chemical; toxicity of 1-1 Dichlor-1-nitro-ethane; toxicity of methyl silicate; toxic effects on animals of methyl, ethyl, and butyl methacrylates.

5TH ANNUAL INTENSIVE POST-GRADUATE COURSE IN OPHTHALMOLOGY

April 7-12, 1941, inclusive

THE GEORGE WASHINGTON UNIVERSITY
SCHOOL OF MEDICINE

1335 H Street, Northwest, Washington, D. C.

REGISTRATION AND FEES, INTENSIVE COURSE

The fee for the Intensive Course is \$50.00, \$15.00 payable with registration. The remainder of the fee of \$35.00 is payable on matriculation.

Please register for this course on Sunday, April 6th, between 5:00 and 7:30 P. M. or on Monday, April 7th, between 7:30 A. M. and 8:20 A. M. The course opens *promptly* at 8:30 A. M., School of Medicine, 1335 H Street, Northwest.

Those who find it necessary to cancel their reservation in the course because of military duties, will receive a refund of the registration fee. No return of this fee is authorized except for this reason.

Also a Practical Course limited to 25 participants in
Ocular Surgery, Pathology and Orthoptics

April 14-19, 1941, inclusive

REGISTRATION AND FEES FOR PRACTICAL COURSE IN OCULAR SURGERY, PATHOLOGY AND ORTHOPTICS

This course is limited to 25 participants who will be accepted in the order in which they enroll for the course.

The fee for this course is \$100.00, \$25.00 payable with registration. The remainder of the fee or \$75.00 is payable on matriculation.

Please register for this course on Monday, April 14th, from 7:30 A. M. to 8:30 A. M. in the School of Medicine, 1335 H Street, Northwest.

NOTICE

Because of the unsettled conditions the University reserves the right to make necessary changes in the courses.

RULES GOVERNING THE AWARD OF "THE FOUNDATION PRIZE" OF THE AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNECOLOGISTS AND ABDOMINAL SURGEONS

(1) "The award which shall be known as 'The Foundation Prize' shall consist of \$150.00."

(2) "Eligible contestants shall include only (a) interns, residents, or graduate students in Obstetrics, Gynecology or Abdominal Surgery, and (b) physicians (with an M.D. degree) who are actively practicing or teaching Obstetrics, Gynecology or Abdominal surgery."

(3) "Manuscripts must be presented under a nom-de-plume, which shall in no way indicate the author's identity, to the Secretary of the Association together with a sealed envelope bearing the nom-de-plume and containing a card showing the name and address of the contestant."

(4) "Manuscripts must be limited to 5000 words, and must be typewritten in double-spacing on one side of the sheet. Ample margins should be provided. Illustrations should be limited to such as are required for a clear exposition of the thesis."

(5) "The successful thesis shall become the property of the Association, but this provision shall in no way interfere with publication of the communication in the Journal of the Author's choice. Unsuccessful contributions will be returned promptly to their authors."

(6) "Three copies of all manuscripts and illustrations entered in a given year must be in the hands of the Secretary before June 1st."

(7) "The award will be made at the Annual Meetings of the Association, at which time the successful contestant must appear in person to present his contribution as a part of the regular scientific program, in conformity with the rules of the Association. The successful contestant must meet all expenses incident to this presentation."

(8) "The President of the Association shall annually appoint a Committee on Award, which, under its own regulations shall determine the successful contestant and shall inform the Secretary of his name and address at least two weeks before the annual meeting."

Jas. R. Bloss, M.D., Secretary,
418 Eleventh Street, Huntington, W. Va.

TREATMENT OF FRACTURES OF HUMERUS

(Continued from page 269)

3. The main object of treatment is to preserve joint function rather than absolute alinement.
4. If the neckshaft axis is end-to-end by 50-60 per cent, a satisfactory functional return will be assured.
5. The let-alone policy is better than manipulation because this may mal-aline instead of re-aline.
6. A non-restricting dressing is adequate.
7. Early regulated motion of the shrugging and "compass" type will aid in preventing the peri-arthritis that so often complicates and which is of itself more disabling than the bony damage.
8. Suspect this injury in contusion-sprain of the shoulder in older patients, just as fracture of the neck of the femur is suspected in so-called contusion-sprain of the hip in persons over 55.

OBITUARIES

Charles Wardell Stiles, M.D.

1867 - 1941

On January 24, 1941, Doctor Charles Wardell Stiles, first to describe the New World hookworm and one of the leaders of the campaign against hookworm disease, died of myocarditis in the U.S. Marine Hospital, Baltimore, at the age of seventy-four. With his death one of the great figures of the modern era of preventive medicine has gone from the scene and a long life of scientific achievement has been ended. As Doctor Stiles in his boyhood attended public school at Hartford and studied at Wesleyan University, Middletown, during the years 1885-1886, citizens of Connecticut have had a special interest in his career. Notable expressions of this feeling were given by Wesleyan in 1896 and again in 1907 when the University awarded him the honorary degrees of M.S. and Sc.D.

After leaving Wesleyan Doctor Stiles studied at several foreign universities and received the Ph.D. degree at Leipzig in 1890. Trained primarily as a zoologist and parasitologist, his expert knowledge of protozoa and helminths were called upon to solve important medical problems. One of the most important of the practical applications of his knowledge was his original description, in 1902, of *Necator americanus*, the New World variety of hookworm, from material sent to him by Doctor Allan J. Smith of Galveston, Texas. As a result of his interest in this parasite and as a natural outcome of his abilities he served as scientific secretary of the Rockefeller Sanitary Commission for the Eradication of Hookworm Disease from 1909 to 1914. During the period from 1894 to 1937 he taught zoology, and particularly medical zoology, at a number of medical schools and universities, including Georgetown, the Army Medical School, the Navy Medical School, Rollins College, and Johns Hopkins. His first M.D. degree was received from the University of Paris in 1894. The honorary degree of M.D. was given him by the University College of Medicine, Richmond, in 1913.

Doctor Stiles' service with the federal government began in 1891 when he was appointed zoologist to the Bureau of Animal Industry of the U. S. Department of Agriculture. In 1902 he was appointed

Professor of Zoology in the U. S. Public Health Service and continued association with that Service until his retirement from active duty as Medical Director in 1931. During the period of his appointment as honorary custodian of the helminthological collection in the United States National Museum from 1893 to 1931, Doctor Stiles published many important systematic papers and volumes, among them a monumental key catalogue of the parasites of man and animals.

Repeatedly during his long life he represented the government and various zoological societies at scientific congresses in this country and abroad. He was a Fellow of many of the learned societies of England and Europe and was distinguished by the award of numerous honorary degrees.

Doctor Stiles was a vigorous, straightforward, systematic zoologist of great renown who knew how to combine his investigations with beneficial applications in public health. The fields of fundamental science, animal husbandry and medical practice were enriched by his labor.

S. Bayne-Jones, M.D.

QUARTO NOTES

MANUEL OF PERIPHERAL VASCULAR DISORDERS. By David Kramer, M.D., Assistant Professor of Medicine, Jefferson Medical College. Philadelphia: The Blakiston Company. 1940. 448 pp. 126 illustrations. \$6.00.

Reviewed by JOHN J. CLANCEY

This is a highly readable text written by an eminent authority who draws on a long and varied experience with diseases of the peripheral blood vessels. It is an attempt to make available to the practitioner the advances of recent years, to bridge from the antiquated idea that all vascular disorders are arteriosclerotic to the present view of multiple etiology. This thesis is introduced in a subtle manner by discussing with remarkable lucidity the multiplicity of tests and devices which have been introduced to study the altered physiology of the vascular system. In this sugar coated manner, the reader is painlessly prepared for the more detailed discussion of the various states of diseased blood vessels which seem, in our present state of knowledge, to constitute entities. There are views which are controversial but controversy is excluded for the sake of clarity. Bibliographical references are carefully selected to substantiate the main points of the running theme. The text is appropriately if not copiously illustrated by well chosen charts and photographs. This short volume should be of great service to the practitioner who is constantly being confronted by these

complicated and often distressing problems. Throughout there permeates a ray of hope for the proper management of early cases.

OFFICE UROLOGY (*With a Section on Cystoscopy*).

By P. S. Pelouse, M.D., Assistant Professor of Urology, University of Pennsylvania Consulting Urologist, Delaware County Hospital. Special Consultant to United States Public Health Service. Member of Board of Directors, American Social Hygiene Association and American Neisserian Medical Society. Philadelphia: W. B. Saunders Co. 1940. 766 pp. 443 illustrations, 19 in color. \$10.00.

Reviewed by BENJAMIN L. SALVIN

This work by a distinguished and practical urologist is an exceedingly useful one to all urologists and the general practitioner. Doctor Pelouse at first outlines several convenient office arrangements for the treatment of urologic disease. He then describes and illustrates each and every instrument and their application. This part of his treatise should be exceedingly helpful to the young physician who is starting his professional career.

The author, in the succeeding chapters, gives a thorough review of the essential anatomy and physiology of the urogenital tract followed by his method of subjective and objective examination of the patient. His correlation of these findings in reaching a definite conclusion is a beautifully written chapter of common sense and keen judgment.

Following the above fundamentals, Doctor Pelouse then discusses very comprehensively the various urologic diseases, using many diagrams and drawings to simplify the diagnostic difficulties one encounters. These diseases are presented in an every day common sense light, giving every detail in technique including the manipulation of the various instruments, so that a complete continuity exists.

The subject of venereal diseases is taken up in great length, particularly the gonococcal infections. The discussion is highly enlightening, particularly in regard to the past and present methods of dealing with this disease. The author warns of the difference in the criterion of cure today, with the use of the sulfonamide drugs, as compared with the older methods with which he was so well acquainted. He brings out the fact that the newer drugs render some cases so asymptomatic that the usual methods of establishing a cure by chemical irritation, prostatic and vesicular massage, and even urethral instrumentation, will often fail to give the examiner any clue or evidence of gonococcal flairup. He cites several cases demonstrating this chemotherapeutic false security and the misfortunes that may follow this peculiar persistent bacteriostasis.

In the concluding chapters an excellent discourse on cystoscopy and uretero-pyelographic study of disease is presented.

This reviewer feels that Doctor Pelouse's book is one of the most complete and practical urologic treatises he has had the pleasure of reading and highly recommends it as an exceedingly valuable addition to one's library.

DISEASES OF INFANCY AND CHILDHOOD. (11th edition.) By the late L. Emmett Holt, M.D., and John Howland, M.D., revised by L. Emmett Holt, Jr., M.D.,

Associate Professor of Pediatrics, Johns Hopkins University and Rustin McIntosh, M.D., Carpenter Professor of Pediatrics, Columbia University. New York: D. Appleton-Century Co. 1940. 1421 pp.

Reviewed by V. P. CENCI

The practitioner is fortunate in obtaining a book on pediatrics written in a descriptive form that is easy to comprehend. The value obtained in this edition is the degree of thoroughness of presenting conditions in the normal, abnormal, and morbid infant, preschool and school child; such thoroughness was made possible by the multiple authorship idea carried out by the author. This edition written in sections dealing with the well and sick individual makes available all that the reader expects of a book with reference to etiology, pathology, symptoms, prognosis, prophylaxis, and treatment.

MANUAL OF CLINICAL CHEMISTRY. By Miriam Reiner, M.Sc., Assistant Chemist to Mt. Sinai Hospital, New York City. New York: Interscience Publishers, Inc. 1941. 296 pp. 18 illustrations. \$3.00.

Reviewed by J. C. ROWLEY

This excellent manual is the outgrowth of one employed in the laboratory of Mount Sinai Hospital, New York, and used in postgraduate courses in clinical medicine given at the Hospital under the auspices of Columbia University. It offers at least one method for every contingency and the author has selected those methods which combine greatest accuracy with greatest simplicity. The procedures given in the manual have been used and revised for a period of over twelve years. Each of them is headed by a reference to the original article and also one or two others to the most recent literature.

Among the subjects covered are blood analysis, urine and gastric analysis, chemotherapy, function tests, toxicological tests, sex hormones, and vitamins.

This thoroughly up to date little book should prove to be of great service to technicians and interns or to clinicians for use in their laboratories.

MACLEOD'S PHYSIOLOGY IN MODERN MEDICINE. (9th edition.) Edited by Philip Bard, Professor of Physiology, Johns Hopkins University School of Medicine in collaboration with nine other leading physiologists. St. Louis: C. V. Mosby Company. 1941. 1256 pp. \$10.00.

Reviewed by J. C. ROWLEY

Recent advances in physiology have been so rapid and extensive that if one physiologist alone attempted to write a textbook, the first chapters would need revision by the time the last was finished. Professor Bard and his contributors, after Professor Macleod's death, not only revised but entirely rewrote the eighth edition in 1938.

The subject matter of this new ninth edition has not only been reorganized and revised but several new chapters on electrical excitation and conduction and on the urinary bladder have been added. The general plan and purpose of the author is that it may serve as a textbook of physiology. To quote Professor Bard, "it makes no pretense of being a textbook of applied physiology and does not supply pre-

digested knowledge suitable for immediate bedside application."

There are seventy pages of references to the literature at the end of the book which is well written and continues to maintain the high standards of the previous editions.

THE 1940 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY. Obstetrics edited by *Joseph B. DeLee, A.M., M.D.,* Professor of Obstetrics, University of Chicago Medical School. Gynecology edited by *J. P. Greenhill, B.S., M.D., F.A.C.S.,* Professor of Obstetrics and Gynecology, Loyola University Medical School, Chicago. *The Year Book Publishers.* 1941. 714 pp. \$2.50.

Reviewed by **STANLEY B. WEID**

The 1940 Year Book of Obstetrics and Gynecology is a Fortieth Anniversary number and as such contains an interesting preface by the publishers narrating the story of this Year Book's origin and development. There are included illustrations of the editors and associate editors since 1900. In addition each of the two parts of the Year Book contains a special article, the one on obstetrics by Doctor DeLee entitled "Fifty Years of Eclampsia, Placenta Praevia and Cesarean Section," the other on gynecology by Doctor Greenhill entitled "Progress in Gynecology Since 1900." Both articles afford an excellent resume of the progress made in these fields since the turn of the century.

The abstracts of literature published during the past year bear testimony to the editorial ability of both Doctors DeLee and Greenhill. Always one of the best of the Year Book Series, this volume is no exception. Doctor DeLee's own comments on some of the literature abstracted are especially entertaining and valuable. In the obstetrical part of the volume one's attention is attracted by the reports on the use of vitamin E and of vitamin K, the use of the corpus luteum hormone in preventing abortion, the plea for more attention to the treatment of cervicitis during pregnancy, and the new classification of toxemias of pregnancy as drawn up by the American Committee on Maternal Health. In the section of the volume devoted to gynecology of particular interest is the work with cobra venom for the relief of pain, Goodall and Quinn's method of preventing postoperative cystitis as well as the whole problem of preoperative and postoperative care, the chronic appendicitis problem, the work of Lewis of New Haven on the treatment of gonococcal salpingitis and arthritis with sulfanilamide, the research work of Burr and Musselman of New Haven on the date of ovulation by means of electrical determination, the use of the male sex hormone, and the classification of ovarian tumors as arranged by Howard C. Taylor of New York City. There is included an excellent chapter on endocrinology with many references to the results obtained with stilbestrol.

PLAGUE ON US. By *Geddes Smith.* New York: *The Commonwealth Fund.* 1941. 365 pp. \$3.00.

Reviewed by **STANLEY B. WEID**

This volume by a layman is written for laymen but physicians will find within its covers an excellent history of many of the communicable diseases such as yellow fever,

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph. Gon. & Ven. Dis.*, 23, 201 (March) 1939.

*Silver Picrate, is a definite crystalline compound of silver and picric acid. It is available in the form of crystals and saluble trituration for the preparation of solutions, suppositories, water-soluble jelly, and powder for vaginal insufflation.

Asiatic cholera, influenza, and malaria. The old theories of pestilence are traced up to the time of their banishment by scientific facts. The actions of bacteria and parasites are explained. There is an excellent chapter on the specific therapy of such diseases as syphilis and pneumonia and a description of the part the body's powers of resistance play in other diseases. The reader is entertained with a chapter narrating the methods utilized in tracing the source of several specific typhoid epidemics.

That portion of the book which probably will be of most interest to the physician is the chapter entitled "Unfinished Business." Here the author with the aid of charts very clearly outlines what yet remains to be accomplished in eliminating the common contagious diseases, including influenza, pneumonia, the common cold, and tuberculosis. The less common diseases as malaria, yellow fever, and plague are not overlooked, and syphilis, poliomyelitis, and encephalitis receive more than passing attention. As the author says, "we are still a long way . . . from putting an end to pestilence." And again, "every advance in the speed of transportation makes it harder to isolate any nation." "There is indeed no finished business in epidemiology."

Each chapter closes with a full list of references as well as a note on sources.

His First Cereal Feeding

The baby's first solid food always excites the parent's interest. Will he cry? Will he spit it up? Will he try to swallow the spoon? Far more important than the child's "cute" reactions is the fact that figuratively and physiologically, the little fellow is just beginning to eat like a man.

It is a fortunate provision of Nature that at the time the infant is ready to receive the nutritional benefits of cereal, his taste is unspoiled by sweets, pastry, condiments, tobacco, alcohol and other things to which adult palates and constitutions have become conditioned.

Many a parent, with limited knowledge of nutrition, attempts to do the baby's tasting for him. Partial to sweets, the mother sweetens her child's cereal. Disliking cod liver oil, she wrinkles her nose and sighs: "Poor child, to have to take such awful stuff!" The child is quick to learn by example, and soon may become poor indeed—in nutrition, as well as in mental habits and psychological adjustment.

Appreciating the importance and difficulties of the physician's problem in establishing and maintaining good eating habits, Mead Johnson & Company continue to supply Pablum in its natural form. No sugar is added. There is no corresponding dilution of the present protein, mineral and vitamin content of Pablum. Is this not worth while?

Table of Contents : May 1941

ORIGINAL PAPERS

DIFFERENTIAL DIAGNOSIS OF LOW BACK PAIN	Paul P. Swett, M.D., Bloomfield	330
CONNECTICUT DOCTORS IN OTHER FIELDS	Herbert Thoms, M.D., New Haven	337
SULFATHIAZOLE TREATMENT OF GONOCOCCAL INFECTIONS IN AMBULATORY PATIENTS	Luca E. Celentano, M.D., and Robert M. Lewis, M.D., New Haven	344

EDITORIAL

Welcome to Bridgeport	347	Annual Physical Examination	351
The General Practitioners' Section	349	Puberty, Adolescence and the Pediatricist	352
Compulsory Health Insurance	349	Good Blood	352
The Eagle and Its Prey	350		

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	353	OUR NEIGHBORS	368
CONNECTICUT HOSPITAL ASSOCIATION	355	NEWS FROM COUNTY ASSOCIATIONS	369
MEDICAL PREPAREDNESS	360	NEWS FROM YALE UNIVERSITY SCHOOL	
THE LEGISLATURE	363	OF MEDICINE	372
THE FORUM	368	LETTERS TO THE EDITOR	399
THE DOCTOR'S OFFICE	369	QUARTO NOTES (Book Reviews)	401

MISCELLANEOUS

PROGRAM—149TH ANNUAL MEETING	321	SPECIAL NOTICES	395
COMMERCIAL EXHIBIT	328	OFFICERS AND COMMITTEE CHAIRMEN	
OBITUARIES	398	Connecticut State Medical Society	4
ANNUAL REPORTS	373	Connecticut Hospital Association	4

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The CONNECTICUT STATE MEDICAL JOURNAL

VOL. V

MAY, 1941

No. 5

PROGRAM • 149th ANNUAL MEETING

Hotel Stratfield, Bridgeport

May 20, 21, 22, 1941

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BERKELEY M. PARMEELEE, Bridgeport
and

DANIEL C. DARROW, New Haven, *Hezekiah Beardsley Pediatric Club*

J. GRADY BOOE, Bridgeport, *Section on Proctology*

KARL B. BRETZFELDER, New Haven, *Section on Physical Therapy*

OWEN J. GROARK, Bridgeport, *Section on Radiology*

WILLIAM H. RYDER, New Haven, *Section on Eye, Ear, Nose and Throat*

MARIO L. GAROFALO, New Haven, *Section on Anesthesia*

GEORGE A. GOSSELIN, Hartford, *Section on Neurology and Psychiatry*

RALPH E. McDONNELL, New Haven, *Section on Dermatology and Syphilology*

FRANK S. JONES, Hartford, *Section on Orthopedic Surgery*

EUGENE F. MESCHTER, Stamford, *Section on Industrial Health*

ELEANOR CALVERLY, Hartford, *Women's Medical Society*

and

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TUESDAY, MAY 20th

- 10:00 A. M. Registration for House of Delegates
- 10:30 A. M. House of Delegates—Rose Room
The President, Arthur B. Landry, Presiding
- 1:00 P. M. Luncheon
Members of the House of Delegates and Officers and Committee Chairmen will be guests of the Society at luncheon
- 2:00 P. M. House of Delegates reconvenes

WEDNESDAY, MAY 21st

GENERAL SESSION—Ballroom: The President, Arthur B. Landry, Presiding

- 9:30 A. M. Registration—Sun Parlor
- 10:00 A. M. Address of Welcome Ralph W. Crane, President Fairfield County Medical Association
- 10:10 A. M. Chemotherapy in Pelvic Inflammatory Diseases—(illustrated)
William E. Studdiford, Director Obstetrical and Gynecological Service, Bellevue Hospital, New York
Discussion opened by Lewis P. James, Hartford
- 10:45 A. M. Progress Report on an Experiment in the Control of Cancer of the Uterus (illustrated)
Catharine Macfarlane, Professor of Gynecology, Woman's Medical College of Pennsylvania, Philadelphia
Discussion opened by Margaret Tyler, New Haven
- 11:20 A. M. Interpretation of Encephalograms, Particularly in Relation to Trauma (illustrated)
Cornelius G. Dyke, Associate Professor of Radiology, Columbia University, New York
Discussion opened by William J. German, New Haven
- 11:55 A. M. The Relationship of Anesthesia to Surgical Shock (illustrated)
Henry K. Beecher, Anesthetist-in-Chief, Massachusetts General Hospital, Boston
Discussion opened by Ralph M. Tovell, Hartford
- 12:20 P. M. Health Plans for Small Industries
Anthony J. Lanza, Metropolitan Life Insurance Company, New York
Discussion opened by Eugene F. Meschter, Stamford
- 1:15 P. M. Luncheons
GENERAL LUNCHEON — Rose Room
INTER PROFESSIONAL RELATIONS
HUGH P. BEIRNE, Commissioner of Pharmacy, State of Connecticut
Women's Medical Society Luncheon-Meeting—Room 343
Report of an Experiment in the Control of Cancer of the Uterus
Catharine Macfarlane, Professor Gynecology, Woman's Medical College of Pennsylvania
Connecticut Hospital Association—Breakfast Room

GUEST SPEAKERS



Schall, LeRoy Allen

Boston. M.D. Jefferson Medical College, 1917. W. Augustus LeCompte Professor of Otology, Harvard Medical School; Professor of Laryngology, Harvard; Chief of Otology and Laryngology, Massachusetts Eye and Ear Infirmary and the Massachusetts General Hospital.



Cipollaro, Anthony C.

New York. M.D. College of Physicians and Surgeons, Columbia University, 1927. Diplomate of the American Board of Dermatology and Syphilology; Associate Dermatologist and Syphilologist, Skin and Cancer Unit, New York Post-Graduate Hospital, Columbia.



Golden, Ross

New York. B.A. Cornell College, Iowa, 1912. M.D. Harvard, 1916. Director, Department of Radiology, Presbyterian Hospital, 1922 to date. Professor of Radiology, College of Physicians and Surgeons, Columbia University.



Smith-Petersen, M. N.

Boston. M.D. Harvard 1914. Chief Orthopedic Service, Mass. General Hospital; Clinical Professor, Harvard Medical School.

WEDNESDAY, MAY 21ST—(Cont.)

3:00 P. M. Section Meetings

OBSTETRICS AND GYNECOLOGY—Ballroom

Chemotherapy of the Pelvic Infections Caused by Hemolytic Streptococcus
William E. Studdiford, New York

ANESTHESIA—Breakfast Room

Mechanisms of Respiratory Failure Under Barbiturate Anesthesia (Evipal, Pentothal)
Henry K. Beecher, Boston
Fluid Balance in the Pre and Post Operative Patient
Jacob H. Fine, Beverly, Massachusetts
Breathing in Anesthesia
Wesley Bourne, Montreal, Quebec

NEUROLOGY AND PSYCHIATRY—Room No. 316

Surgical Treatment of Mental Disorders
Walter Freeman, Washington, D. C.
Problems of Civilian Mental Health
D. Ewen Cameron, Albany

INDUSTRIAL HEALTH—Room No. 311

Relation of the Industrial Physician to the Medical Profession and General Public
Anthony J. Lanza, New York City

3:30 P. M. CONFERENCE OF SELECTIVE SERVICE PHYSICIANS — Rose Room

Presiding, George M. Smith, Chairman Committee on Medical Preparedness

OPERATION OF THE SELECTIVE SERVICE

Colonel Ernest L. Averill, Director of Selective Service, State of Connecticut

PSYCHIATRIC SUGGESTIONS CONCERNING SELECTION FOR MILITARY SERVICE

Eugen Kahn, MD., Sterling Professor of Psychiatry and Mental Hygiene, Yale University
School of Medicine

QUESTION AND ANSWER PERIOD

Major William B. Smith, Medical Officer attached to the Selective Service System

5:00 P. M. Cocktail Hour—Carribean Bar

7:00 P. M. ANNUAL DINNER OF THE SOCIETY — Rose Room

Arthur B. Landry, Presiding

HIS EXCELLENCY, ROBERT A. HURLEY, GOVERNOR OF CONNECTICUT

EDUCATION BEGINS AT THIRTY

Remsen B. Ogilby, President, Trinity College, Hartford

GUEST SPEAKERS

Alexander, Hattie E.

New York. M.D. Johns Hopkins Medical School, 1930. Associate in Pediatrics, Columbia; Assistant Attending Pediatrician, Babies Hospital and Vanderbilt Clinic.

Beirne, Hugh P.

Hartford. PHAR.D. Yale University 1911. Secretary - Treasurer State Pharmacy Commission. Secretary Connecticut Fair Trade Committee. Member of Board of Trustees, Connecticut College of Pharmacy.



THURSDAY, MAY 22nd

GENERAL SESSION—Ballroom: G. Gardiner Russell, Chairman Program Committee, Presiding

- 9:30 A. M. House of Delegates final meeting—Breakfast Room
 Cancer of the Upper Respiratory Tract (illustrated)
 LeRoy A. Schall, Professor of Laryngology, Harvard Medical School, Boston
 Discussion opened by Paul B. MacCready, New Haven
- 10:10 A. M. Skin Diseases of Childhood (illustrated)
 Anthony C. Cipollaro, Associate Dermatologist and Syphilologist, Skin and Cancer Unit, New York Post-Graduate Hospital, New York
 Discussion opened by Ellwood C. Weise, Bridgeport
- 10:50 A. M. Roentgen Ray Examination in the Treatment of Ileus With the Miller-Abbott Tube (illustrated)
 Ross Golden, Professor of Radiology, College of Physicians and Surgeons, New York
 Discussion opened by Douglas J. Roberts, Hartford
- 11:30 A. M. Treatment of Influenzal Meningitis (illustrated)
 Hattie E. Alexander, Associate in Pediatrics, Diseases of Children, Columbia University, New York
 Discussion opened by James R. Trask, New Haven
- 12:10 P. M. Sciatica from An Orthopedic Point of View (illustrated)
 M. N. Smith-Peterson, Chief of Orthopedic Department, Massachusetts General Hospital, Boston
 Discussion opened by Arthur S. Griswold, Bridgeport
- 1:15 P. M. PRESIDENT'S LUNCHEON — Rose Room
 James R. Miller, Chairman of the Council, Presiding
 ADDRESS OF RETIRING PRESIDENT, Arthur B. Landry
 INTRODUCTION OF THE PRESIDENT, JAMES D. GOLD, AND THE PRESIDENT-ELECT
- 3:00 P. M. Section Meetings
 EYE, EAR, NOSE AND THROAT—Ballroom
 Rhinology and Oral Surgery, Their Interrelation and the Necessary Coöperation of Both Specialists (illustrated)
 Theodor Blum, M.D., D.D.S., New York City
 Discussion opened by Philip J. Sheridan, D.M.D., Hartford
 Vitamin Therapy in Ophthalmology (illustrated)
 Arthur M. Yudkin, New Haven
 Discussion opened by Joseph Laval, New York City
 Cavernous Sinus Thrombosis (illustrated)
 LeRoy A. Schall, Boston
 Discussion opened by William J. German, New Haven
- GENERAL MEDICINE — Organization Meeting — Rose Room
 Arthur B. Landry, President of the Society, presiding
 Address: A General Practitioner's Section
 Mr. James E. Bryan, Executive Secretary, The Medical Society of the County of Westchester, New York
- ORTHOPEDIC SURGERY—South Parlor
 Vitalin Mold in Arthroplasties of the Hip (illustrated)
 M. N. Smith-Petersen, Boston

GUEST SPEAKERS



Studdiford, William Emery

New York. M.D. New York University, 1922. Director Obstetrics and Gynecology, Bellevue; Professor of Obstetrics and Gynecology New York University; Consultant, Obstetrics and Gynecology, Greenwich Hospital, Conn. and St. Joseph Hospital, Far Rockaway, New York.



Macfarlane, Catharine

Philadelphia. M.D. Woman's Medical College of Pennsylvania. Chief, Department of Gynecology, Woman's Medical College of Pennsylvania.



Beecher, Henry K.

Boston, M.D. Harvard, 1932. 1936 to date In charge of teaching Anesthesia at Harvard. Anesthetist-in-Chief the Massachusetts General Hospital. Exchange Lecturer to the National University of Columbia, South America.



Lanza, Anthony J.

New York. M.D. George Washington University Medical School, 1906. Assistant Medical Director, Welfare Division, Metropolitan Life Insurance Company.

Dyke, Cornelius G.

New York. M.D. State University of Iowa, College of Medicine, 1926. Assistant Professor of Radiology, Columbia University, College of Physicians and Surgeons.

THURSDAY, MAY 22ND—(Cont.)

HEZEKIAH BEARDSLEY PEDIATRIC CLUB OF CONNECTICUT—Breakfast Room
 Severe Infections due to the Organism Causing Influenzal Meningitis
 Sydney E. Sinclair, New Haven
 Discussion opened by Hattie E. Alexander, New York

PHYSICAL THERAPY—Room No. 343

Physical Therapy in Some Gynecological Conditions
 Madge C. L. McGuinness, New York City

DERMATOLOGY AND SYPHILOLOGY—Room No. 311

Cutaneous Manifestations of Tuberculosis and Treatment (illustrated)
 Anthony C. Cipollaro, New York City

RADIOLOGY—Room No. 316

Radiologic Studies of Disease of the Small Intestine (illustrated)
 Ross Golden, New York City

PROCTOLOGY—Room B-3

Facts and Fallacies Regarding Proctologic Diseases (illustrated)
 Martin S. Kleckner, Allentown

6:00 P. M. Section Dinners

Physical Therapy—Stratfield Hotel
 Dermatology and Syphilology—Stratfield Hotel
 Eye, Ear, Nose and Throat—Stratfield Hotel

6:30 P. M. Section Dinners

Eye, Ear, Nose and Throat—Stratfield Hotel
 Dinner speaker, Mr. James A. Hamilton, Director of New Haven Hospital
 Radiology—Brooklawn Country Club

TECHNICAL EXHIBITS, HOGARTH LOUNGE

The Connecticut State Department of Health
 The Connecticut Pharmaceutical Association
 The Connecticut Occupational Therapy Society
 The Connecticut Tuberculosis Association, Inc.

ORGANIZATIONS MEETING AS GUESTS OF THE CONNECTICUT STATE MEDICAL SOCIETY

WEDNESDAY, MAY 21ST

11:00 A. M.—5:00 P. M. The Connecticut Hospital Association—South Parlor

1:00 P. M. The Women's Medical Society of Connecticut—Room No. 343
 Report of an Experiment in the Control of Cancer of the Uterus
 Catharine Macfarlane, Professor of Gynecology, Woman's Medical College of Pennsylvania

3:00 P. M. American Society of Anesthetists—Breakfast Room

9:30 A. M.—1:00 P. M. The Connecticut Occupational Therapy Society—Room No. 311

9:30 A. M.—1:00 P. M. Hospital Medical Records Librarians' Association of Connecticut—Room No. 316

THURSDAY, MAY 22ND

10:30 A. M.—1:00 P. M. Connecticut Branch, American Association of Medical Social Service Workers—Room No. 311

COMMERCIAL EXHIBIT

John H. Bumstead, M.D., Director

Booth No. 1

Parke, Davis & Company, Detroit

Featured in the Parke-Davis Exhibit will be the sex hormones, Theelin and Theelol; antisyphilitic agents, such as Mapharsen and Thio-Bismol; posterior lobe preparations, including Pituitrin, Pitocin and Pitressin; and various Adrenalin Chloride Preparations.

Booth No. 2

Burroughs Wellcome & Co., Inc., New York

Burroughs Wellcome & Co., Inc., presents a representative group of fine chemicals and pharmaceutical preparations, together with new and important therapeutic agents of special interest to the medical profession.

Booth No. 3

Ciba Pharmaceutical Products, Inc., Summit, N. J.

Featured in the Ciba Exhibit will be a display of fine specialties including gynecogenic and androgenic substances and synthetic and esterified adreno-cortical hormones.

Booth No. 4

The Sun-Rayed Company, Frankfort, Ind.

The Sun-Rayed Company, producers of Kemp's Sun-Rayed Tomato Juice, are exhibiting the natural, pasteurized juice of a new strain of Indiana tomatoes, sun-ripened on the vines, and U. S. Government graded. The whole, carefully cored tomato is converted into juice by Kemp's patented process No. 1746657, which utilizes all the tender solids for high retention of vitamins A, B-1 and C, insures non-separating color and never thin or watery consistency.

Booth No. 5

Nestle's Milk Products, Inc., New York

Visitors to the exhibit of Nestle's Milk Products, Inc., will be entertained by the famous Nestle mechanical cow, who rolls her eyes, wiggles her ears, flicks her tail and moos softly.

Booth No. 6

H. J. Heinz Company, Pittsburgh

The H. J. Heinz Company will display and demonstrate Heinz' strained and junior foods and distribute literature on the subject of nutrition including the new 9th edition of the nutritional chart.

Booth No. 7

Scientific Sugars Company, Columbus, Ind.

Scientific Sugars Company will display Cartose and the Kinney line of Vitamin B. Complex preparations.

Booth No. 8

Lederle Laboratories, Inc., New York

Lederle Laboratories, Inc., will feature a display of their Hay Fever, Poison Ivy and Allergenic products together with selected pharmaceutical products and Globulin Modified Antitoxins.

Booth No. 9

McKesson & Robbins, Inc., Bridgeport

McKesson & Robbins, Inc., will display vitamin products and demonstrate laboratory procedures in their production.

Booth No. 10

John Wyeth & Brother, Inc., Philadelphia

John Wyeth & Brother, Inc., will exhibit a comprehensive line of pharmaceutical specialties.

Booth No. 11

Mead Johnson & Company, Evansville, Ind.

Mead Johnson & Company will exhibit several new products in addition to Dextri-Maltose, Pabulum and Oleum Percomorphum. They will also have on display various examples of the slogan "Servamus Fidem"—"We are Keeping the Faith."

Booth No. 12

E. L. Washburn & Company, Inc., New Haven

E. L. Washburn & Company will present an early showing of the newest equipment.

Booth No. 13

Bedford Surgical Company, Inc., Brooklyn

Bedford Surgical Company, Inc., will show the latest Continental equipment, including the new fluoroscope, two models of accepted short wave apparatus, a new mercury-quartz ultra violet lamp, a new galvanic and sinusoidal apparatus, a new electro-surgical suite of office equipment.

Booth No. 14

Davies, Rose & Company, Ltd., Boston

Davies, Rose & Company, Ltd., will exhibit pharmaceuticals that have been clinically tested and accepted, including the recent addition to the firm's specialties, tablets of guanidine hydrochloride.

Booth No. 15

C. B. Fleet Company, Lynchburg, Va.

Phospho Soda (Fleet), the buffered saline laxative. Combines two U.S.P. salts of sodium phosphate in a staple concentrated solution of broader therapeutic range and is free from most of the disadvantages of saline laxatives.

Booth No. 16**Petrolagar Laboratories, Inc., Chicago**

Representatives in attendance have an interesting story to tell of the numerous uses of Petrolagar for the treatment of constipation. Samples and literature pertaining to the Five Types of Petrolagar will be available at the booth or, if physicians prefer, will be mailed on request.

Booth No. 17**Surgeons' & Physicians' Supply Co., Boston**

There will be a display of the latest in Comprex short waves and other electrical devices such as cold cautery scalpel, Hyfrecator, spotlights, and centrifuges, and a line of surgical instruments and sundries.

Booth No. 18**Eli Lilly and Company, Indianapolis**

Eli Lilly and Company will demonstrate the germicidal efficacy of 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly) and the compatibility of the antiseptic with body cells and fluids. Other new and useful products will be featured.

Booth No. 19**The Borden Company, New York**

The Borden Company will exhibit Biolac, the new liquid modified milk for infants, and other Borden products for infant feeding, notably Klim, Dryco, Beta Lactose, Merrell-Soule products and Borden's Irradiated Evaporated Milk.

Booth Nos. 20-21**The Professional Equipment Company, New Haven**

The Professional Equipment Company, distributors of

medical, surgical and x-ray equipment and supplies in Connecticut, will exhibit some of the latest developments in the medical and surgical fields.

Booth No. 22**The D. G. Stoughton Company, Hartford**

Supplies of interest to physicians and hospitals. Allison wood furniture, metal furniture, Castle sterilizers and lights, Mooradian short wave, McKesson anesthesia and oxygen therapy apparatus, B. L. B. and nasal catheter outfits, McKesson and Metabolor blood pressure apparatus, diagnostic sets, surgical instruments and rubber sundries, complete line of dressings, drugs and biologicals.

Booth No. 23**Philip Morris & Company, Ltd., Inc., New York**

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Booth No. 24**J. B. Lippincott Company, Philadelphia**

Two new books will be on display at the Lippincott booth. Grollman's Essentials on Endocrinology and Tobias' Essentials of Dermatology. Other important works on display are Thorek's Modern Surgical Technic, Barboraka's Treatment by Diet, the second edition of Anus, Rectum, Sigmoid Colon by Harry E. Bacon, as well as two sensational sales leaders: Becker's Modern Dermatology and Syphilology and Leaman's Management of the Cardiac Patient.

**STATE OF CONNECTICUT
PERSONNEL DEPARTMENT
EXAMINATION NOTICES**

POSITIONS: Assistant Superintendent (Psychiatric) \$6000-\$7200 per annum less maintenance; Physician and Psychiatrist \$4800-\$6000 per annum less maintenance; Senior Physician (Psychiatric) \$3240-\$5160 per annum less maintenance; Assistant Physician (Psychiatric) \$2520-\$3900 per annum less maintenance; Director of Clinical Laboratories \$4500-\$5700 per annum less maintenance; Senior Physician \$3240-\$5160 per annum less maintenance; Assistant Physician \$2100-\$2400 per annum less maintenance; Local Health Consultant \$5100-\$5700 per annum.

RESIDENCE: The Connecticut residence is waived.

APPLICATION FORMS and detailed information may be obtained at the Personnel Department, State Capitol, Hartford.

CLOSING DATE: Applications for all the above positions must be filed with the Personnel Department not later than May 15, 1941.

DATES OF EXAMINATIONS: Between May 25 and June 15, 1941.

PROFESSIONAL HEADACHES:— Few medical men can run an office without having an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co., New Haven.

(SEE PAGE 2)

THE DIFFERENTIAL DIAGNOSIS OF LOW BACK PAIN

PAUL P. SWETT, M.D., *Bloomfield*

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THE TITLE suggested for this paper was the differential diagnosis of low back pain of orthopedic origin. However, it seemed best to dispense with any qualification because there is no dividing line between the various origins of low back pain which is not better overlooked until a diagnosis is made. This problem belongs to the orthopedic surgeon and there is no easy way out of it any more than there is in the problem of foot disability. The differential diagnosis in the latter is impossible without a thorough grasp of the arthritic, circulatory and neurological possibilities. In the same way, the differential diagnosis of low back pain is doomed to failure unless the potential causes in the neighboring tissues and organs, as well as the circulatory, the neurological and the numerous constitutional factors are fully considered.

The number and the variety of disorders which may be involved in low back pain are simply staggering. Gone are the days when a man of John Ridlon's caliber could justifiably say that it was nonsense to attempt to differentiate between lumbago and lesions of the sacro-iliac joints, because the same cases that Goldthwait cured with a steel brace and Ansel Cook cured with a pink belly band, Ridlon cured with senna tea. Gone, too, are the days when Cook could consolingly tell a patient that the trouble was either tubercular, rheumatic or traumatic and that it fortunately made no difference which it was since the same treatment was equally effective for any of these conditions.

There are no pathognomonic signs or symptoms by which any single cause of low back pain can be certainly known. Even an apparently typical tuberculous lesion is likely to turn out to be a manifestation of brucellosis and there have been instances of negative operative findings following positive radiographic lipiodol examinations. The differential diagnosis of low back pain therefore necessitates cer-

tain prerequisites without which most of our diagnostic conceptions will result in abortion.

Prominent among these prerequisites is the mental and emotional attitude of the clinician. More important than his knowledge of the possible entities and syndromes, more essential than his technical ability and even more valuable than a clear conception of the vital integration of the psychic with the somatic factors in all diseases, more important than any of these are open-mindedness, freedom from the blighting effects of habit, lack of prejudice and intellectual honesty.

Specialization in fixed fields of interest together with specialization within these fields has the inevitable effect of narrowing the viewpoint. This is plainly shown by the characteristic tendency to solve problems in terms of one's own specialty. Thus, a given civic problem submitted to an architect would be solved in architectural terms, while an economist would seek a solution in terms of economics or an engineer would concern himself with an engineering solution. This phenomenon is now so well recognized that modern city planners seek to put in authority only such persons as lack any special training and are, therefore, something like general practitioners.

In the field of orthopedic surgery and in its application to the low back problem this phenomenon is manifested by the tendency of body mechanics enthusiasts to solve the differential diagnosis in terms of body mechanics and posture, while the more surgically trained clinician tends to see the situation in terms of operative surgery. At the same time the neurologically trained men lean towards a psychogenic or neurologic explanation of the same sort of cases. Speaking for myself I must confess that due to my early training by Ansel G. Cook, I am impelled to seek balance, in viewpoint and in technique, in the hope of eventually arriving at a balanced opinion.

An open mind is necessary for the reception of all possible ideas. That this attitude is not invariably present is shown with startling clarity by the persistent neglect of the principles of body mechanics in their application to diagnosis and to treatment.

Nothing else can explain this neglect since the validity of these principles is readily demonstrable. The lack of an open mind is evidenced by the common failure to include in one's deliberations the full significance of psychogenic and emotional factors in relation to the back; the one place where these factors most commonly exhibit their ill effects.

Of course no sane person deliberately closes the doors of his mind through evil intent. It is more accurate to say that a mind is never voluntarily closed. What happens is that the effects of habit, custom, tradition and prejudice create impenetrable barriers. Thus when a man is trained in a clinic where the emphasis is placed on some particular aspect of the matter, or upon a special approach towards the problem, or upon some temporary enthusiasm or hobby of the directing head, it is natural for that man to follow the custom of that clinic. With the passage of time and with repetition, the practice becomes habitual. Carried on over a period of years custom becomes traditional. Around traditions barriers of prejudice are erected until the time is finally reached when the suggestion of a different approach is regarded as heresy. This was illustrated several years ago when the residents in a certain hospital were beginning an operation for the stabilization of a flail foot. A newcomer mildly hinted that this might be a good case for an astraglectomy only to be quickly suppressed by his senior who said "shut up! Do you think you are down on 42d Street?" By these reasons it is seen that the essential prerequisite for the differential diagnosis of low back pain is the proper mental and emotional attitude on the part of the clinician.

Next in order of importance, as part of the foundation required by the diagnostician, is an understanding of all the possible pathological conditions which may be responsible for low back pain. Since it is manifestly impossible in one paper to cover all the ground it is intended only to touch upon certain of the high spots as they occur to me.

Progress, like the tide, is manifested by an ebb and flow. Just now, we as orthopedic surgeons are in the stage of ebb tide. For several years we have emphasized the mechanical concepts of low back pain and in stressing the postural, the anomalous and the traumatic together with the local nature of the problem we have neglected the equally important constitutional aspects. This custom has made us too much concerned with a narrow particularism, with our attention so focused on the exact location

of the disorder that we have lost sight of the more fundamental question of the nature of the condition. It is demonstrably less important to know the exact location of a strain than to know with certainty that the pain does not result from an inflammatory or a degenerative process. There has been too much attention given to the distinction between a sacro-iliac and a sacro-lumbar disorder, upon the one side, and too little consideration given to the differentiation between a strain and a neurosis, for example.

This is a regressive tendency and its continuance will bring upon orthopedic surgery discredit which it can ill afford. There is not a real dichotomy between mechanical lesions of the low back and inflammatory lesions. It is not possible for the latter to exist without accompaniment by the former. Even in low back pain of neurotic origin there soon follows some degree of postural strain.

Philosophy is said to be an attempt to see the part in terms of the whole; an impossible undertaking but the only way by which we can ever hope to penetrate the veil which hides knowledge. In the case of low back pain it is necessary to make this effort; otherwise the record will continue to be stained by those blindspots, schisms and failures which, in the past, have caused us so much distress and our patients so much suffering, and which now is bringing contemptuous glances from other clinicians who, in some quarters, are inclined to thrust us back into the horse and buggy days of our recently outgrown period of strap and buckle therapy.

In many diseases the therapeutic test is rightly given an important place in differential diagnosis. The use of this test is nowhere more conspicuously valuable than in the problem of low back pain. Here this test centers around the use of local rest. By means of adequate rest nearly all traumatic disturbances can be relieved or cured; from the least to the greatest, injuries are helped by rest; even fractures will heal, in time, with rest. Failure with this therapeutic test usually results from its inefficient application, or because of an unawareness of the superimposition of other factors than trauma; such factors as neurosis, focal infection, contractures of the soft parts and the atrophy of disuse. Such superimposed factors may act singly or in every conceivable combination.

Adequate local rest for the low back requires relatively complete immobilization together with

removal from the low back of the superincumbent weight of the head, chest and trunk. These provisions necessitate the use of recumbency in the nearest possible approach to the physiological posture. These requirements must be maintained for a sufficient length of time and it is of paramount importance that this period should be followed by muscle training and graduated active movements to promote the restoration of muscle strength, and coördination and muscle and ligamentous tone, before ordinary functional use is again undertaken. For rest to this extent it is essential to provide a rigid bed, a fracture board or a Bradford frame, together with Buck's extension in the mild cases and long bilateral plaster spicas in the severe cases. In either event the distorting influence of muscle spasm must be overcome in order that the posture during immobilization may be truly physiological. If contractures have already occurred manipulation under an anaesthetic is necessary before applying the immobilizing apparatus. To conclude that rest has been ineffective in any instance where it has been applied on a standard in the slightest degree less than this is to be led into serious and inevitable error. If these standards are scrupulously applied and if the rest period is adequate, and if muscle training and active exercises are competently carried out, many of the baffling problems will disappear and the sorry spectacle of the old chronic back hopelessly wandering from clinic to clinic will be eliminated. While this is eminently true of the recent cases it is even more true for the older cases so many of whom have, by the time they reach the orthopedist, become the victims of secondary strains, contractures and deformities.

In the occasional instances of failure of this therapeutic test it is useful to remember that the effects of focal infection often are exhibited first in traumatized areas. Whenever, therefore, adequate rest is not followed by improvement it must first be demonstrated that there is not present a focus of infection before dismissing the tentative diagnosis of trauma. This idea still holds good in spite of the present tendency to belittle the importance of focal infection in connection with the arthritides. In this, as in many other instances in medicine, empiricism weighs more heavily in the scales of truth than the lack of experimental demonstration or convincing abstract theory.

In the consideration of the differential diagnosis of low back pain the next most important element after

the therapeutic test is the mechanism by which certain pathological states, resulting from the original trouble, become, in turn, etiological factors, themselves capable of prolonging or extending the original disorder. The mechanism by which such a transformation occurs is illustrated by what may, and often does happen, in a mild unilateral sacroiliac strain. Protective muscle spasm confined to one group of muscles causes a lateral listing of the trunk and this posture induces additional strain in standing, sitting and walking which contributes to a continuance of the original traumatic strain or induces further strains which add to the problem. If spasm is continued long enough the muscles undergo contractures which prolong the deformity and thus further the extension of the original difficulty.

This transformation of pathological states into etiological factors is more easily seen in the flexor contractures which often follow acute conditions in the knee joint where even the most unaccustomed mind can perceive what is going on. The evidences of this mechanism as they are found in the low back are more subtle and they unfortunately escape apprehension in too many instances. However, the train of symptoms and signs set in motion by lumbar extensor spasm carried on until contractures develop ought to be so well understood that they could not embarrass any orthopedic surgeon. Unfortunately the evidence shows that in some of the best clinics this whole matter escapes the attention it merits; otherwise there would not be exhibited before clinical groups so many cases in which lumbo-sacral fusion had been performed in the presence of a forward tilting pelvis, a sharp hyperlordosis and a sagging abdomen. These things still occur in spite of the fact that everyone knows that extensor spasm is one of the earliest and most consistent occurrences in the majority of cases of low back pain regardless of the origin of such pain; and in spite of the realization that recovery never can be complete while the deformity of hyperlordosis with its resultant abdominal and psoas atrophy persists. The etiological importance of the pathological contracture of the fascia lata and the ilio-tibial band has, perhaps, been over-emphasized lately but this may be a blessing if, by this means, the significance of this and other such contractures is brought to more general attention. Since the first objective of orthopaedic surgery is to prevent deformity there clearly devolves upon us the duty to treat the early stages of low back pain along lines which will obviate the

later necessity for the operative correction of such contractures. It is a sad commentary on the practice of orthopedic surgery to note the enthusiastic reception of fasciotomy by those who should know better. These contractures are preventable by the use of those principles now so commonly employed in the treatment of infantile paralysis; and most of them are remediable by manipulation and subsequent immobilization. To abandon such basic procedures and blithely adopt the operative method represents a backward step suggestive of those who have learned a trade instead of having acquired a profession.

Running a close second, as an etiological factor, to muscle contracture is the muscle atrophy which is another pathological state transformed into an etiological factor. The integrity of the low back is dependent upon the strength and the coördinated functioning of the abdominal, the extensors of the back and the psoas groups of muscles. Just as no attempt at differentiation of low back pain that overlooks the element of contractures can be expected to be successful, so, also is differentiation doomed to failure without an adequate consideration of the influence of muscle atrophy. Many instances of protracted lumbo-sacral discomfort, baffling in their perverse persistence, probably depend upon abdominal and thigh flexor atrophy. If, to this, there is added considerable gluteal atrophy the stage is set for the patient to have a chronic backache of indefinite duration.

In their effective influence as causes of prolonging low back disorders it is probable that, singly or in combination, the factors of muscle spasm, contracture and atrophy are more devastating than the etiological factors originally responsible for the onset of symptoms. It also is probable that such factors are of greater importance than anomalies of the bones and joints and, at the least, they merit equal therapeutic attention. Less glamorous than operative surgery, the humble spade work applied to the prevention and correction of deformity, the development of muscle strength and the revival of muscle coördination will usually lead to better results. In any case the existence of contractures and atrophy requires for differentiation the use of the therapeutic test just as this test is required in traumatic disorders. Therefore, it is necessary to overcome the effects of these twin pathological results which have been transformed into etiological factors before it is possible to decide that a developmental anomaly

or some form of arthritis is the dominant cause of the trouble.

The psychogenic aspects of low back pain merit greater emphasis in differential diagnosis than they usually receive, especially in those clinics where tradition has become fixed in the direction of mechanics and operative surgery. In the words of Adler, a neurosis manifest itself in the region which is the seat of an organ inferiority. Because the low back is so often the seat of mechanical and physiological inferiority it often provides the locale of neurotic disorders. To this there is added an emotional complex provided by the close relationship between the back and the sexual occupations which are the common preoccupations of mankind. Thus it is that sexual frustrations and dissatisfactions often are compensated or disguised by expressions of low back pain. This is so common amongst both men and women that it demands the utmost attention in every instance of low back pain the somatic cause of which is not perfectly clear and in many cases in which mild degrees of postural or anomalous changes might readily be erroneously accepted as the true explanation.

In this connection the devastating effects of fear also assume significant proportions. An injured workman who persistently remains disabled may be influenced by fear fully as much as by cupidity. Fear of his inability to continue at work after he again resumes it, and fear of loss of employment, bring on deep-rooted concern for future economic security. Thus the morale declines, muscle atrophy increases and the symptoms continue. It is difficult even for those of the toughest moral fiber to stiffen the back under a load of constant fear and worry.

The association of functional disorders of the low back with cases involved in personal liability litigation is too commonly seen to warrant extended comment. However, it is necessary always to have this matter in mind if mistakes in differential diagnosis are to be avoided.

The power of suggestion is fully as potent in keeping patients sick as in curing them. There can be no doubt that fear of the unknown and the unexplained is a factor in the persistence of low back pain. One of the commonest means for providing adverse suggestion is through the clinician's carelessness in making premature and ill-considered reference to the possibility of future operative surgery. Another common way to upset a patient is by an attitude of doubt and uncertainty on the part of

the clinician. It is not necessary to be either untruthful or to be pretentious in order to be reassuring and comforting to a patient, but it is necessary to realize that all truth is relative and that no person can grasp the truth beyond his own capacity to perceive and to understand. Therefore, in our discussions with the patient it is our job to give him a comprehensible explanation to which he can tie up in confidence and serenity.

The incidence of localized fibrositis probably is more frequently overlooked than that of any other local disease in the low back. For some reason this condition has received scant attention from clinicians and writers, perhaps because this entity has failed to create in our minds the impact which its importance merits. Fibrositis is described as an isolated or discrete local inflammation occurring in fibrous tissue. It is marked by local pain, which may become radiating, and by local tenderness of exquisite type. A recent biopsy on such a lesion showed an area of distinct round cell infiltration but, in spite of many pathological descriptions to the contrary, there was found no evidence of encapsulation. Favorites amongst the many locations of fibrositis are the fascia and the ligaments of the low back.

These lesions are capable of causing reflexly referred pain, particularly in the course of the sciatic distribution, in the manner so well described by Steindler in his discussion of the relation between the so-called "trigger point" and referred reflex pain. Since fibrositis is a variant form of rheumatoid arthritis and is, therefore, liable to appear in the back without relation to underlying local conditions, it is important to recognize its existence in order to differentiate it from the more commonly considered disorders. As a rule the recognition of a fibrositis is fairly easy because of the distinct localization of the tenderness and the relative absence of extensive physical signs pointing in any other direction. It is within the bounds of probability that the presence of a definite trigger point usually if not invariably, results from a localized fibrositis. Certainly it is consistent with what is known about this lesion that it should occur in the typical places where trigger points are most common; the interspinous ligaments, the muscle attachments to the ilium and the sacrum and in the mid lumbar and mid gluteal regions.

The popularity of protrusion of an intervertebral disc and hypertrophy of the ligamenta flava as the explanation of low back pain and sciatica is likely

to divert attention from simpler and more probable explanations. A recent report from the Mayo Clinic covering a period of three years and including a series of ten thousand cases of low back pain and sciatica, shows that a diagnosis of protrusion of the disc was made in only three hundred cases; this is about three tenths of one per cent.

The available evidence points to trauma as the chief cause of rupture of the disc; fifty-nine per cent of the Mayo cases gave a history of active trauma and forty-one per cent while not giving a history of such trauma mostly represented men doing heavy work. This properly raises the question as to what type of trauma is competent to produce such injuries. In this connection it is noteworthy that compression fractures are common in the thoracic spine and rare in the lumbar area, while in ruptures of the intervertebral disc the opposite is true. This suggests the possibility that the thoracic cage directs the force of a severe hyperflexion accident against the vertebral bodies while in the lumbar region unguarded by the chest wall, such a force may bear more strongly upon the disc. On this basis it may be assumed that a trauma competent to rupture a disc would have to be of sufficient degree to produce a fracture if it were exerted against the thoracic region.

With a history of a competent trauma, severe sciatica and low back pain, especially if the pain is intermittent, a careful neurological examination is needed to determine the tendon reflexes, the muscle strength, the presence of sensation, including pain, temperature, touch, vibratory and joint or position sense, as well as sphincteric tone. Spinal puncture is indicated in the presence of neurological findings—Lasegue's sign, sciatic tenderness, diminished or absent Achilles reflex, muscle weakness and sensory loss. With the spinal puncture there are included a Queckenstedt test to determine the presence or absence of intraspinal pressure producing a partial or complete subarachnoid block. A cell count is made to differentiate between inflammatory and irritative lesions. The total protein is determined because in many irritative lesions an increase of total protein is the only sign.

It must not be forgotten that tumors of the thoracic or the cervical regions may cause sciatic pain. Before the patient is subjected to a laminectomy, which means before an opaque medium is injected, the last remaining diagnostic step is the therapeutic test by a period of conservative treat-

ment. If, under rest, extension and epidural injections there is an increase in the pain a laminectomy probably will be required. The reason for this is made clear by the realization that the pain results from pressure on the nerve roots within the spinal canal; that such pressure is caused by a combination of foreign body (fragment of a disc, hypertrophied ligamenta flava, exostoses, tumor or abscess) together with swelling. The characteristic intermittence of the symptoms in these cases is due to a reduction of the swelling and if it can be permanently reduced without laminectomy, the symptoms may be indefinitely relieved. There is little doubt that in the past many cases of ruptured disc and hypertrophy of the ligamenta flava were symptomatically cured by conservative means.

Neighboring pathology accounts for an incalculable number of cases of low back pain; and for an equally incalculable number of erroneous diagnoses. There is no sense in deceiving ourselves on this score. It is simply to state a fact which must be obvious to all to say that too little attention is customarily paid to this aspect of the differential diagnosis of low back pain. Such conditions as hydro-nephrosis and renal calculus, gall bladder disease, retro-peritoneal adenitis and abscess, retro-cecal appendicitis, visceroptosis, dilatation of the colon and sigmoid, uterine and ovarian tumors, as well as pregnancy, are common causes of low back pain. Besides the characteristic evidences of these conditions, which can, as a rule, be found if they are looked for, it should be borne in mind that flexor spasm and eventual contracture commonly accompany these conditions. Such flexions may affect the lumbar spine or they may cause a flexion of the thigh at the hip. Therefore, there must always be a thorough study of the abdominal possibilities in every case which shows any degree of flexion. Such flexion is quite different from the commonplace limitation in hyperextension though this often occurs in the early stages.

Nothing in the field of low back pain merits more study than the great group of disorders associated with structural anomalies and postural variations. Either of these conditions may exist singly, although they usually are found together, but, whether alone or combined, they are also commonly found to co-exist with any of the other varieties of low back pain.

A postural defect may depend upon an anomaly such as lumbarization of the first sacral vertebra or

a sacralization of the fifth lumbar vertebra, or it may depend upon the presence of a bifid lamina, fishtail transverse processes, partial or complete spondylolisthesis, vertical placement of the articular processes or a horizontal position of the sacrum. At the same time such structural defects can exist without significant postural alterations. This fact coupled with the further fact that all of these conditions can be present without necessarily being the cause of the patient's symptoms explains the necessity for the utmost care to avoid overlooking the real cause of the symptoms in any given case.

Significant evidence of postural alterations is found in extremes of extension and flexion which, wherever they originate, are invariably accompanied by similar changes in all parts of the spine because of the great capacity for compensation which resides in the back. The typical picture is that of hyperextension in the lumbar region with accompanying increased flexion in the thoracic area and a narrow upper abdomen and a sagging lower abdomen. Usually there also is a forward tilting pelvis and there often are further compensatory increases in the normal curves in the cervical region. Less typical but of equal clinical importance is the opposite picture which is marked by a loss of or a diminution of the lumbar lordosis and a decrease in the usual thoracic posterior curve.

The symptoms produced by changes in the body mechanics, whether they are merely postural, entirely structural or due to a combination of both factors, are set in motion by the strain of functional use or, occasionally, by the effect of a single trauma, one so slight that it would not have disturbed a normal back. Another precipitating cause of symptoms in backs of this sort is the loss of strength in the trunk muscles which occurs in sedentary workers or in persons whose occupations require the prolonged assumption of those postures which increase the abnormal extensions and flexions of the back. That the integrity of the trunk muscles is a vital element in this whole picture is shown by the frequency of low back pain secondary to disturbed body mechanics amongst office and factory workers as compared to the relative absence of such cases amongst laborers, athletes and farmers.

Since the element of altered body mechanics is capable of inducing strain it is necessary to take this factor into consideration as an element in the continuance of low back pain even though the primary cause is obviously something quite different. Here,

as in every other low back disorder, there are no pathognomonic signs and a correct diagnosis can be reached only by a complete analysis of the patient and the elements thus found must then be synthesized into a valid whole. Even then it may not be possible to be certain of the diagnosis without a therapeutic test by rest, protection or support of adequate extent and duration together with exercises for the correction of the gross postural irregularities. In this connection it is essential that the shortened soft tissues should be stretched before the corrective exercises are started. This is the hazard over which so much diagnostic and therapeutic effort stubs its toes. A forward tilted pelvis cannot be corrected as long as there remains any shortening of the lumbar extensor structures. Such shortening can often be overcome by a period of rest in recumbency and extension and this is, therefore, a necessary preliminary to active exercises. Another element of basic importance in the exercises is the development of coordination between the muscle groups; even the strongest trunk muscles are incapable of maintaining proper postures unless they function coordinately.

In conclusion, it is evident that the differential diagnosis of the low back pain must be initiated by a balanced attitude on the part of the clinician and carried out with scrupulous regard for the importance of every step in the techniques of history taking, physical examination, laboratory and radiographic studies. Out of the elements of such an analysis there must then be created a synthesis which truly represents the patient's problem rather than an academic abstraction without value in reality. Such a synthesis will not be valid unless it also incorporates, as the cornerstone of its foundation, an accurate combination of the psychic and the somatic factors.

No one realizes better than I do that this presentation falls short of completeness. However, since its statement is the first step in the solution of any problem, I hope that in this respect at least, the reader's time has not been wholly misspent.

List of Applicants Who Were Recommended for Licensure at the March Examinations

- Charles Petrill—133 Spring St., Meriden, Conn.
 James F. Ferguson—122 Canner St., New Haven, Conn.
 Vladimir Gurewich—423 West 120th St., N. Y. C.
 Morgan Y. Swirsky—Grace Hospital, New Haven, Conn.
 Hans Peter Schwartz—William Backus Hospital, Norwich, Conn.
 Sidney Drobnes—Norwich State Hosp., Norwich, Conn.
 Samuel C. Sheiman—Kings County Hospital, Brooklyn, N. Y.
 Norbert Landecker—335 Orange St., New Haven, Conn.
 Rudolf A. Colmers—Stamford Hospital, Stamford, Conn.
 Thomas Thale—Norwich State Hospital, Norwich, Conn.
 David H. Bates—Woodstock, Conn.
 John D. Moriarty—Norwich State Hospital, Norwich, Conn.
 Erich Goldmeier—Lawrence Memorial Hospital, New London, Conn.
 Stefanie Z. Roth—21 Garden St., New Haven, Conn.
 Gerald Krosnick, 574 Elm St., New Haven, Conn.
 Charles C. Verstandig—Station Hospital, Fort Devens, Mass.
 William G. Ames—177 Liberty St., Meriden, Conn.
 Irving B. Akerson—297 Mill Plain Road, Fairfield, Conn.
 Carroll C. Beach, Jr.—14 Fern St., Hartford, Conn.
 Paul S. Hansen—Kings Corner, Essex, Conn.
 Paul R. Johnson—1101 Beacon St., Brookline, Mass.
 Josef A. Kindwall—336 Hartford Ave., Wethersfield, Conn.
 John W. Kinley—411 Talmadge Ave., Cuyahoga Falls, Ohio
 Marjorie C. Meehan—Fairfield State Hospital, Newtown, Conn.
 Gerard R. Miller—Manchester Memorial Hospital, Manchester, Conn.
 Holmes E. Perrine—Neuropsychiatric Institute, Hartford, Conn.
 Pasquale Piccolo—286 Humphrey St., New Haven, Conn.
 Frederick A. Post—717 Howard Ave., New Haven, Conn.
 Clifford F. Ryder—601 W. 110th St., N. Y. C.
 Donald A. Walker—Veterans Home, Rocky Hill, Conn.
 Edwin C. Weinraub—1241 Pawne Place, N. Y. C.

CONNECTICUT DOCTORS IN OTHER FIELDS

HERBERT THOMAS, M.D., *New Haven*

The study of the lives of physicians who were eminent in fields other than medicine is ever fascinating for the influence of medical training on such careers is an interesting speculation. Examples are many. In our own time immediately come to mind such men as the statesmen Clemenceau, the sculptor Tait McKenzie, the novelist Maugham, and the theologian and musician Schweitzer, to mention but a few. From the roster of Connecticut physicians whose lives found expression in other fields the list is a notable one, and an illustration I have chosen out of the past seven Connecticut doctors who became thus eminent. Let us consider, therefore, a theologian, an explorer, a statesman, a journalist, a poet, an educator, and a naturalist, all of whom are truly identified with Connecticut Medicine.

Above an entry in the Harkness Quadrangle at Yale is engraved the name of a Connecticut doctor who was not only the first physician of his day in Connecticut but eminent as a Congregational minister. Jared Eliot of Killingworth came rather directly by his conjunction of physic and divinity, for his father practised both professions and his grandfather was John Eliot, the famous "Apostle to the Indians".

Born in Guilford in 1685, Eliot was graduated at Yale in the class of 1706. The College was then located at Killingworth (Clinton) under the leadership of Rector Pierson. The next year following Piersons' death the young graduate was called to be Pastor of the First Church at Killingworth. His medical education was probably mostly received from his father. William H. Welch said of him, "Of all those who combined the offices of clergyman and physician, not one from the foundation of the American Colonies attained so high a distinction as a physician as Jared Eliot". As a clergyman it is said that for forty years he never missed preaching on Sunday either at home or abroad.

Jared Eliot also was famed as a successful agriculturist and metallurgist. As the former so much valued were his contributions that they were published in a volume in 1760. As a metallurgist it is recorded that the London Society of Arts awarded him a gold medal for his "Essay on the Invention or Art of Making Very Good, if not the Best, Iron from Black Sea Sand". In 1756 he was made a member of the Royal Society of London. Among his celebrated friends were numbered Bishop Berkeley, Ezra Stiles, John Bartram, and Benjamin Franklin. The latter always stayed at the Eliot home when he journeyed through New England. As a medical teacher Dr. H. B. Ferris said that Eliot probably trained more than fifty students, and eulogized him as "Botanist, scientific and practical agriculturist, metallurgist, man of affairs, trustee of Yale, preacher, and physician, and the first donor to the Yale Library Fund—there was nothing more for him to do".

"It may be questioned" writes Bourne, "whether any book of American authorship in the eighteenth century achieved a more instant or a more widespread international reputation than the 'Travels' of Jonathan Carver." In his authoritative Literary History of the American Revolution Moses Coit Tyler found it difficult to restrain his enthusiasm for the unsurpassed value and genuine delight of this early work on travel in America. Both the book and its author should interest Connecticut physicians, for the former as an "Indian book" still remains an exciting story of adventure and the latter was definitely identified with the medical profession in Connecticut. Although Jonathan Carver was born in Weymouth, Massachusetts, in 1710 he lived from 1718 to middle life in the town of Canterbury. Here as a youth he studied medicine, probably with Dr. Joseph Perkins of Lisbon, an adjoining town. It is not known whether Carver actually practised, but about 1755 he entered the Colonial Army and continued through the French and Indian War to 1763 and rose, according to his own statement, to the rank of Captain. Carver informs us that, "No sooner was the late war with France concluded and peace established by the Treaty of Versailles in the year 1763, than I began to consider . . . how I might continue still serviceable, and contribute, as much as lay in my power, to make that vast acquisition of territory, gained by Great Britain in North America, advantageous to it." His plan was to explore the extreme western British possessions and if possible discover a northwest passage to the Pacific. After a journey of nearly 7,000 miles he returned to New England and not finding a publisher there went to London where his "Travels through the Interior Parts of North America" appeared in 1778. The work became immediately popular, went through many editions and was translated into all modern languages. The work was edited by no less a person than Doctor John Coakley Lettsom who befriended its previously obscure and penniless author. A contemporary writer states that not only did the famous Lettsom edit the work but that he paid for its publication and advanced funds to Carver and his family for their support. Some historians have conjectured, not without considerable evidence, that the noted physician was the real author of the work. Indeed, the literary style which so captivated Tyler suggests that the author was a gifted writer. However, Jonathan Carver, once identified with the practice of medicine in Connecticut, certainly furnished the material. He remains a notable and important early explorer of North America.

About a mile to the south of the center of the Town of Wallingford is a boulder memorializing the birthplace of a Connecticut doctor who, perhaps more than any physician of his time, exerted a powerful influence for liberty during the revolutionary struggle. Lyman Hall, a signer of the Declaration of Independence from Georgia, was born in Connecticut, was educated here and spent half the years of his life within the borders of his native state.

It is interesting to note that three of Yale's four "signers" were in College at the same time and one of these, Oliver Wolcott, was a classmate

of Lyman Hall, Yale 1747, and also practised medicine.

Hall originally prepared for the ministry and was ordained, and settled as a pastor in Fairfield. Fortunately for the cause of American liberty, after a few months he got into difficulty with the church leaders and was dismissed by them. He then turned his attention to medicine and is said to have practised for a time in his native town. In 1756 Doctor Hall removed to South Carolina and later joined a colony of New Englanders in Midway Settlement, in the Parish of St. John, Georgia. When the people of this parish, the so-called "Puritan Element" in that state, learned that Georgia had failed to place itself in line with the twelve other colonies, they rallied under the leadership of Lyman Hall and on March 21, 1775, elected him to represent them in the Continental Congress, where he was admitted as a delegate. Within a few months under his influence the State of Georgia joined the confederated colonies. At the signing of the famous document Hall was present with four other members of his profession. These were Josiah Bartlett of New Hampshire, Oliver Wolcott of Connecticut, Benjamin Rush of Pennsylvania, and Matthew Thornton of New Hampshire. Following the revolution Lyman Hall settled in practice in Savannah and shortly afterward was elected Governor of Georgia. During his term of office he "sounded the keynote and paved the way for the foundation and sustenance of the University of Georgia". Upon the memorial which I have previously mentioned are written these significant words, "This rock from Connecticut soil marks the beginning of the life of one of the living stones which, coming from this town, formed the foundation of our Republic" . . .

Although Lyman Hall's classmate, Oliver Wolcott, is chiefly renowned as a patriot and a statesman, he was educated for medicine and practised for a short time in Goshen. His notable record in Congress and on the field of battle is a matter of common history. Oliver Wolcott had the distinction of being a Governor, the son of a Governor, and the father of a Governor of our state.

Toward the close of the eighteenth century there existed in the City of Hartford a group of young men known to us as "The Connecticut Wits". They represent the first real literary movement in America, and although they failed to establish the great national literature which they contemplated, they did much to tranquillize the political turmoil of their times and performed real service in modernizing the rigid classical curriculum of the collegiate learning of that day.

Elihu Hubbard Smith, born in Litchfield, was one of the physician members of that coterie, others being Lemuel Hopkins and Mason Fitch Cogswell. Although but twenty-seven years of life were all that were allotted to Elihu Hubbard Smith, these years were crowded with achievement. He contributed to our national poetry and published the first Anthology of American Verse, wrote many medical essays of distinct merit and was pre-eminent in editing the first medical journal published in America. Following his graduation from Yale in 1786 Smith spent two years at Green-

field Hill under Timothy Dwight, after which he returned to Litchfield and began the study of medicine under his patriot father, Doctor Reuben Smith. Two years later he went to Philadelphia and attended courses under Benjamin Rush and others. After receiving his diploma he began to practise in Wethersfield, and at the establishment of the Hartford County Medical Association in 1792 he is found in the capacity of clerk. During this period he came into contact with the "Friendly Club" of literary spirits in nearby Hartford. This influence induced him "to bring together in one view the several poetical productions of the different states". "American Poems, Selected and Original" printed in Litchfield in 1793, is now a much prized collector's item. In this year also he removed to New York City and, in spite of youth and a limited acquaintance, within three years was elected one of the attending physicians of the New York Hospital. The brief span of five years which he was to live in New York were those of great activity. Many essays came from his pen, both medical and literary. He was active in the antislavery movement and wrote on this and other subjects, including natural history. It is interesting to record that this versatile young man composed an opera in three acts which was produced in 1794. In conjunction with Samuel L. Mitchill and Edward Miller he began the publication of our first medical journal "The New York Medical Repository". In the midst of such professional and literary activities Elihu Hubbard Smith became a victim of yellow fever during the dread epidemic of 1798. His life of intense activity only partially fulfilled reveals a potentially real greatness.

In the year 1828 the New York Mirror published a group of portraits entitled "Nine Living American Poets". The central figure of this group was a Connecticut doctor, James Gates Percival, who was then regarded as the most promising of American poets. Even Bryant was a secondary consideration at that time. It is not easy to imagine a more versatile intellect than that of Percival. He had a remarkable career as a physician and poet, was famous as a geologist and linguist, and during his life was variously known as a lawyer, schoolmaster, anatomist, botanist, and newspaper editor.

The son of a doctor, Percival was born in Kensington in 1795. Almost from the beginning his life was a long struggle with despondency and ill-health. It is not surprising, therefore, to find him as a young man pursuing a vacillatory course of education at Yale interspersed with attempts at school teaching and the life of a literary artist. Even his medical career was interrupted by the study of law and he was admitted to the bar. In 1820 he finally received his medical degree from the Yale Medical School and shortly after lectured in anatomy there. A short period of practice in Kensington soon discouraged him and he then became the curator of a botanical garden in New Haven. Only mention can be made of his variegated career from this time. His success as a poet was such that Whittier wrote "God pity the man who does not love the poetry of Percival. He is a genius of Nature's making". He was one time editor of The Connecticut Herald and through his friend, John C. Calhoun, obtained a professorship at West Point, where he taught

chemistry. Later as Post Surgeon at Boston he was honored by being asked to deliver the Phi Beta Kappa poem at Harvard. For a few years he corrected the proof sheets of Webster's Dictionary, a role in which he actually took great pleasure. His ability as a linguist may be judged by a letter written by him to George Tichnor in 1834 in which he maintains his familiarity with Latin, Greek, Italian, French, German, Spanish, Portuguese, Dutch, Danish, Swedish, Sanscrit, Basque, Hebrew, Gaelic, Welsh, Norse, Hungarian, and Russian. It was as a geologist that Percival did his most enduring work, and his "Report on the Geology of Connecticut" published in 1842 remains today an authority. Prof. James D. Dana stated that "No one in the country has done better work in Geology or work of greater value to the science". James Gates Percival was a man of great intellectual power and, in spite of a life of contention with poverty, ill-health and despondency, through an earnestness of effort obtained fame in both literature and science.

In the writings of William Andrus Alcott are found these words,

"A physician must be essentially a missionary of health. He must feel that to preach this part of the everlasting Gospel, as well as that of the moral or religious teacher, is indirectly to spread the Gospel of the Soul".

Born in Wolcott in 1798 the author of these lines lived a life of usefulness which was the embodiment of this Doctrine. Alcott's field as a writer was not that of belles lettres but chiefly in the field of primary education. However, he wrote on other subjects—medical, religious, and even juvenile fiction. His published writings total no less than 108 volumes. Alcott was a cousin of the "archangel" Bronson Alcott of Concord fame, and though endowed with the same missionary spirit nevertheless chose more mundane fields for the expression of his endeavors. William Alcott spent a considerable part of his early life as a young man as a schoolteacher. Feeling that a medical degree might give him academic standing he tutored with a local practitioner for two years and spent a year at the Medical Institution of Yale College, obtaining a diploma in 1826. For a short time after this he practised medicine without much success. His interest in primary education led him to abandon his practice to assist William Channing Woodbridge in his new school founded on the principles of Pestalozzi. In 1831 he wrote his classic "Essay on the Construction of School Houses" which was awarded a premium by The American Institute of Instruction.

Alcott's interest in promoting hygienic living led him by both teaching and writing to recommend the teaching of Anatomy and Physiology to the population at large. His important part in the establishment of the American Physiological Society has recently been emphasized by my colleagues H. E. Hoff and J. F. Fulton on the occasion of the Centenary of that organization. Suffice it to say that he was its first President and undoubtedly wrote the constitution of that Society. Not only by the influence of his voluminous writings but by his personal activity did he preach the value of education and the importance of healthful living.

Alcott's chief avocation was traveling, in order to collect facts concerning schools. In 25 years he is said to have made 10,000 visits of this kind in Massachusetts, Rhode Island and Connecticut. His medical writings are of great interest to us today for, although they were written almost exclusively for the lay reader, in them we see that he anticipated many of the health movements of our time. Periodic health examinations, medical inspection of schools, child welfare work, physical education, and training schools for nurses were all recommended by him. William Andrus Alcott was indeed a notable "missionary of health". One of his kinsmen has written "He was an earnest worker for humanity, the great purpose and aim of his life was to make men better, to raise them physically, intellectually and morally".

"Jared Potter Kirtland, Physician, Teacher, Horticulturist and Eminent Naturalist", so reads the title of a Presidential Address given not so long ago by Professor F. C. Waite before the Ohio Academy of Science. The citizens of our State should share in honoring the subject of this address, for Jared Potter Kirtland was a Connecticut doctor who spent most of the first thirty years of life in his native state. Born in Wallingford in 1793, Kirtland came early under the guidance and tutelage of his famous grandfather, Doctor Jared Potter, who inculcated in the young boy an absorbing interest in the classics and a love for natural history. Even as a lad we find that he carried on experiments in improving fruit trees by budding and grafting. At the age of twelve he made his first important scientific discovery by showing that the silkworm can reproduce parthenogenetically, preceding Siebold's work on this subject by fifty years.

When Jared Potter died in 1810, the grandson began the study of medicine with Doctor John Andrews of Wallingford and Doctor Sylvester Wells of Hartford at the same time studying as a private pupil under Eli Ives and the elder Silliman. In 1812, at the age of 19, he became the first matriculant in the newly founded Yale Medical Institution. After one season he went to the University of Pennsylvania where, under Barton the botanist, he wrote a thesis. The next year Kirtland returned to Yale and graduated in 1815 at the age of twenty-one. Shortly after this he settled in practice in Wallingford and it is of significance that within a year he was elected Judge of Probate. Subsequently for five years he practiced in Durham, Connecticut. In 1823 his wife and second child died and in a despondent mood he decided to move to Poland, Ohio, to enter business with his father. However, in spite of this intention, after settling there he found an active medical practice forced upon him. This practice in a rural town gave him opportunity for studying nature with the result that he made more important discoveries in that science. In 1829 he described for the first time the sex differentiation in the fresh water bivalve *Mullusca* and in 1840 published the discovery of the byssus, the larval organ of attachment in this species. As a result of these studies he became known in Europe and he established a friendship and correspondence with Agassiz. Kirtland was elected three times to the State Legislature and when the first geological and zoological survey of Ohio was

made he was placed in charge of zoology. Out of this came his notable pioneer work on the Fishes of Ohio. Kirtland's zoological interests were chiefly in the study of fishes and birds, and our ornithological friends will be interested to know that the warbler *Dendroica Kirtlandi* was named for him. In the field of zoology over 70 papers are credited to him and as popularizer of science through writings in agricultural and horticultural journals he was pre-eminent.

Even in the art of Taxidermy he became an expert and specimens of his art may be found in museums both in this country and abroad. In 1865 the Cleveland Academy of Natural Science was renamed the Kirtland Society of Natural History as a tribute to his fame. In addition to many other honors may be counted his membership in the American Academy of Science and the American Philosophical Society. Jared Potter Kirtland's medical career was also notable. In 1837 he became professor of the theory and practice of medicine in the Ohio Medical College at Cincinnati, and later occupied the same chair in the Cleveland Medical School, now the School of Medicine of Western Reserve University. He continued in this latter position until he was seventy-one. These are but the highlights of the career of a Connecticut doctor who became great in both natural science and medicine. His biographer Waite concludes his admirable essay with these words: "It remains for us, and those that follow us, to develop those qualities which characterized the personal career of Jared Potter Kirtland, namely, catholicity of interest, orderliness, and personal industry".

In the foregoing group it is interesting to note that all but one engaged in medical practice at one time or another, and some became eminent in that field. This is also true of other Connecticut doctors whose names would embellish a similar list. We may but mention John Winthrop, scholar and statesman, Joshua Porter, jurist and industrialist, Gershom Bulkeley, clergyman, Lemuel Hopkins, man of letters, Melines Conklin Leavenworth, botanist, and Worthington Hooker, educator.

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(SEE PAGE 2)

SULFATHIAZOLE TREATMENT OF GONOCOCCAL INFECTIONS IN AMBULATORY PATIENTS

LUCA E. CELENTANO, M.D. AND ROBERT M. LEWIS, M.D., *New Haven*

Doctor Celentano. B.S. *Trinity* 1924. M.D. *Habnemann Medical College* 1930. Assistant Attending Physician, *Grace Hospital, New Haven, Conn.*

Doctor Lewis. B.A., *University of Pennsylvania* 1907, M.D., 1910. Associate Clinical Professor Gynecologist and Obstetrician *Yale School of Medicine.* Attending Gynecologist and Obstetrician *New Haven Hospital*

UNTIL RECENTLY, the treatment of gonococcal infections in both men and women has been very unsatisfactory. It has been time consuming and immediate recovery has occurred in only a small percentage of cases. The patient has remained infectious for months. A recognition of the possibilities inherent in the use of sulfathiazole entirely changes our attitude toward this prevalent contagious disease.

Gonococcal infections are more than twice as frequently reported as syphilis, and the commonly given incidence is more than twice as high in men as it is in women. We find in the New Haven Department of Health reports that during the past 6 years 1,379 cases of infections in the male were reported as compared with only 273 cases in the female.

We believe that more male cases are reported because the symptoms become much more troublesome and discernable in males than in females, and not because females are less often infected. We also believe that the total number of cases reported is far less than those that actually exist. Many presumptive cases of gonococcal infection are not reported by physicians because of the lack of confirmatory laboratory evidence. In the female a positive diagnosis that can be upheld in court is often determined with difficulty. Without positive smears (spreads) or cultures the physician hesitates to report cases because he does not consider them proven gonococcal infections. As an illustration of this difficulty, one may quote J. F. Mahoney's¹ investigation of 1,598 presumably infected prostitutes. In this group there were only 97 positive smears and only 21% of the culture yielded gonococci. If a physician has good reason to suspect that cervicitis in a given case is gonococcal in origin, he is justified in prescribing sulfathiazole as a diagnostic test. If the infection then promptly vanishes, he

Table 1 gives the number of cases reported from 1935 through 1940.

TABLE 1

	MALE	FEMALE	TOTALS
1935	306	52	358
1936	231	32	263
1937	215	42	257
1938	218	50	268
1939	191	43	234
1940	218	54	272
Totals	1,379	273	1,652

Table 2 gives a picture of the situation in the State of Connecticut:

TABLE 2

SEX AND MARITAL STATUS OF ALL CASES OF GONORRHEA REPORTED IN CONNECTICUT 1935-1939

	MARITAL STATUS	SINGLE	MARRIED	DIVORCED AND SEPARATED	WIDOWED	NOT STATED	TOTALS
1935	Male	740	346	21	21	115	1,243
	Female	154	128	9	6	14	311
	Sex not stated	20	9	1	0	21	51
1936	Male	660	292	24	15	118	1,109
	Female	178	145	14	8	21	366
	Sex not stated	16	4	1	0	27	48
1937	Male	638	307	23	5	121	1,094
	Female	159	155	14	10	22	360
	Sex not stated	10	12	2	2	16	42
1938	Male	563	258	38	9	143	1,011
	Female	104	124	18	8	25	279
	Sex not stated	8	2	1	0	9	20
1939	Male	529	220	35	12	125	921
	Female	97	85	17	9	19	227
	Sex not stated	4	1	0	0	15	20

is entitled to conclude that his suspicions were well founded.

Carpenter² has shown that carefully taken cultures are more than twice as successful as are

spreads in detecting gonococcal infections in women. This observation has been repeatedly confirmed by others. Unfortunately, the facilities for culture are not available to the majority of practicing physicians. Material for cultures must either be inoculated directly on culture plates for incubation, or kept not longer than five hours in proteose-peptone #3 broth or some similar solution before transplanting to plates. Repeated experiments by Cohn, Lewis, Mahoney, Adair and others have shown that there is a rapid decrease in the number of cases which will give positive cultures if a longer time interval than this elapses before transplantation to plates. After placing the material in #3 broth, it should be kept cold, or even in a refrigerator until inoculation on plates is possible. This prevents overgrowth of gonococci by other bacteria. In June 1939 Vonderlehr³ said: "We await with eagerness the development of a simple technic for collecting and transmitting specimens to the laboratory for the culture of gonococci." We still await the discovery of such a procedure. Until this is found cultures cannot be of widespread and general use.

When sulphanilamide was introduced high hopes were entertained that it might prove a specific cure for gonococcal infections. Pelouze,⁴ after a study of its use in different clinics, concluded that with this drug ordinarily not more than 30 per cent of good results had been obtained within the first month. In the New Haven Municipal Venereal Disease Clinic the results of sulphanilamide therapy have been rather unsatisfactory. Cures were obtained in 49 per cent of males and in no females.

Reviewing our results in dispensary cases before the introduction of the sulfonamides we find that 50 men whose histories were selected at random from our files, were under treatment for an average of 4.8 months before we considered them cured. In a series of twelve women treated for gonococcal infections with local applications we find that an average of 14.3 months elapsed before they were considered cured. The enormous advantage of this new form of therapy will be better appreciated if these figures are compared with those given in a later paragraph, dealing with results of treatment with sulfathiazole. In the New Haven Municipal Venereal Disease Clinic, sulfathiazole* has been used since June, 1940. All of us are convinced of its extra-

ordinary efficacy in the treatment of gonococcal infections.

To those of us, who had experience with the frequent toxic effects produced by large (gm. 4 to gm. 6 per day) doses of sulphanilamide and sulfapyridine, this type of treatment seemed unsuited to out patient dispensaries. Fortunately J. F. Mahoney,⁵ was able to show that sulfapyridine and sulfathiazole if given in doses not exceeding gms. 2 per day would cure gonococcal infections as effectively as the same drugs given in larger doses. Mahoney and his associates, using approximately this dosage, reported cures in slightly more than 85% of their cases treated with sulfapyridine. This fact is of the greatest importance, enabling us to treat ambulatory patients safely and successfully.

In our own Clinic we have adhered to Mahoney's method and used sulfathiazole in both males and females as follows: grams 2 (grains 30) daily for twelve days only. This is divided into four doses, taken at 8 A. M., 12 noon, 4 P. M., and 8 P. M. Patients are warned that no other drug is to be taken during the time they are taking sulfathiazole. Sexual excitement and alcohol are prohibited. No other restrictions are ordered. Local treatment is not given except in females who are allowed warm water douches if the discharge is troublesome. Actually the discharge vanishes so rapidly that douches are rarely needed. Patients are instructed to stop taking the tablets if they develop fever, vomiting, diarrhea, severe headache or body rash. All patients visit the clinic on Monday, Wednesday and Friday while under treatment. Thereafter they report once a week for two months and in the case of women once every two weeks for two more months.

In women, as a proof of cure we consider an observation period of four months necessary. All spreads and cultures from the cervix, urethra and Bartholin's glands must be negative throughout this period, and must be taken at least once a month. The cervix must appear normal and there must be no purulent discharge.

Our proof of cure in men requires eight weeks' observation after they have become symptom free. The urine must be free of pus and shreds. At the end of eight weeks patients are discharged as cured if negative smears are obtained following prostatic massage and the passage of urethral sounds.

Ordinarily men experience extraordinary improvement and symptomatic relief within 48 to 96

*By courtesy of E. R. Squibb & Sons we have been supplied with sulfathiazole for the treatment of gonococcal infections since June 1940.

hours. In women the cervicitis and discharge commonly show great improvement in the same length of time. If no improvement occurs during the first six days of treatment sulfathiazole is stopped and the case rated as a failure.

We here report the results of treatment with sulfathiazole in 35 men and 25 women. Thirty three of the 35 men and, in our opinion, all the women, were rapidly cured. Of the men, 18 had been given sulphanilamide previously with no success. Under sulfathiazole treatment 10 of these patients became symptom free in 5 to 7 days, 3 were symptomless in 4 days, one in three days, and 4 in two days. Of the seventeen who had sulfathiazole only, 13 were symptom free in 5 to 7 days, one in 3 days, one in 2 days, one was delinquent after the first visit, and one patient showed no improvement whatever. None of these patients had any type of untoward reaction, whereas 5 of the 18 who had had sulphanilamide previously, had reported toxic reactions to that drug. These 33 cured patients were followed as outlined above and fulfilled our criteria of cure. Of the 25 females, 11 had acute gonococcal infections, yielded positive spreads and cultures, and had received no other treatment. These 11 patients had negative smears in 5 days and reported no toxic reaction to the drug. Fourteen were chronic cases which we had treated before sulfathiazole became available. All had been treated locally with silver nitrate and six had been given sulphanilamide with no apparent improvement. Three had been unable to tolerate sulphanilamide. Two of these fourteen patients did not return for treatment and follow up. The cervix in each of the twelve remaining patients showed marked improvement in appearance after the use of sulfathiazole, and appeared cured of their gonococcal infections. Two patients, after apparent cure, showed spermatozoa in the smear taken from the cervix. Both admitted intercourse with infected partners and both developed what we may fairly call re-infections.

We feel it is important to outline our method of taking smears and cultures in the female. Patients are warned not to douche during the 24 hours before the clinic visit, and not to urinate just before examination. The urethra is milked with the index finger before the smear is taken. Bartholins' glands are also milked. Then the bivalve speculum is inserted. The cervix is cleansed with cotton. The thumb screw of the speculum is released and the cervix is squeezed between the lips of the speculum. This expresses

some of the secretion from within the cervix. The swab is then inserted well into the cervical os, and rolled rather than rubbed over the slide.

Table 3 gives a complete summary of total cases treated with results.

TABLE 3

	MALE	FEMALE
Total cases	35	25
Acute cases	35	11
Previously unsuccessfully treated with		
Sulphanilamide	18	0
Reactions to Sulphanilamide.....	5	0
Treated only with Sulfathiazole.....	17	11
Symptom free with Sulfathiazole in 5 to 7 days....	23	9
Symptom free with Sulfathiazole in 4 days	3	1
Symptom free with Sulfathiazole in 3 days	2	1
Symptom free with Sulfathiazole in 2 days	5	0
Chronic cases	0	14
Previously unsuccessfully treated with		
Sulphanilamide	0	6
Reactions to Sulphanilamide.....	0	3
Treated only with Sulfathiazole.....	0	8
Chronic cases apparently cured with Sulfathiazole	0	12
Failures with Sulfathiazole.....	1	0
Delinquent	1	2
Toxic reactions to Sulfathiazole.....	0	0

None of our patients, either male or female, developed any complications, such as salpingitis or posterior urethritis after treatment was begun. Since sulfathiazole treatment has been instituted at our clinic, the total number of visits has been materially reduced. Table 4 shows the number of visits for the last three months of the years 1939 to 1940.

TABLE 4

VISITS TO CLINIC FOR TREATMENT OF GONORRHEA	1939	1940
October	419	319
November	399	224
December	417	191

CONCLUSION

In our opinion sulfathiazole is far superior to any type of treatment we have used heretofore in gonococcal infections. Other investigators^{6,7,8,9,10,11,12,13}, have also reported excellent results.

By materially shortening the period of infectivity in gonorrhea the opportunity for the spread of infection is lessened. Now that we have an effective treatment and cure for gonococcal infections we confidently expect a reduction in the incidence of this disease.

REFERENCES

1. Mahoney, J. F., Van Slyke, C. J., and Wolcott, R. R.: The Venereal Disease Research Laboratory, U. S.

(Continued on page 394)

CONNECTICUT STATE MEDICAL JOURNAL

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Used manuscripts will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

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NEWS: Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physi-

cians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS: All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

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EDITORIALS

Welcome to Bridgeport

Cities, like people, have personalities. They have characteristics by which they may be identified. They have qualities which attract or repel. There are attributes for which they are distinguished—major features which we consistently associate with their individual names.

For instance, Hartford has wealth, New Haven has culture, Bridgeport has enthusiasm. (Gr.—to be inspired or possessed by the God). These various possessions are not, of course, mutually exclusive. We will concede, for instance, that Hartford, too, has culture and that New Haven enjoys a certain degree of prosperity. Bridgeport, however, has everything.

So, in welcoming to this friendly community fellow practitioners from other cities and states, the physicians of Bridgeport promise all an enthusiastic greeting and a warmth of hospitality befitting the occasion. These same physicians are honored in being chosen to play host for a group of friends whose presence at this convention will again reveal

their lively interest in medical and surgical progress which is the leading characteristic of the progressive practitioner.

The program committee has arranged a series of presentations of timely subjects—chemotherapy, encephalography, anesthesia and surgical shock, the Miller-Abbot tube, childhood skin diseases, influenza meningitis, cancer of the larynx, and that perennial, sciatica. Guest speakers will be present from many cities of Eastern United States and from Canada. The guest speakers for the Annual Dinner are to be His Excellency, Governor Robert A. Hurley and Remsen B. Ogilby, President of Trinity College. Bridgeport hospitals are large but not top-heavy; the program is varied but not confusing; the exhibits cover a wide range of worthy products—there will be no doubtful merchandise on display.

Now, more than ever, physicians in every branch of practise need the stimulus of inspiring instructors, the opportunity of examining new and approved appliances, the chance to solidify old friendships and make new contacts. Come to the Convention.



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The General Practitioners' Section

Medical practice is passing through one of the greatest upheavals it has ever known. So much is transpiring within our own country that we are almost breathless in our attempts to keep pace. Hospital insurance, various plans for medical care, specialty certifying boards, the growing changes in medical education, and now the changing status of the general practitioner. If, as Doctor Fishbein has said, 80% of the ills of our people can be cared for by the general practitioner and his little black bag it must be obvious to many, if not to all, that this particular gentleman is receiving very little attention in these turbulent days. On all sides we learn of physicians preparing for this specialty and that, taking examination for some particular certifying board or pursuing postgraduate work in some specialty. While all this is transpiring the general practitioner continues to be the family councilor in medical matters, the liaison officer (some have called him an errand boy) between his patient and one or more specialists, the bulwark of medical practice in every community. In many hospitals he has found his position on the staff so curtailed that he is permitted to do little more than leave his patient at the main entrance. He has been criticized by his fellow practitioners for not availing himself of some of the opportunities for postgraduate education. Perhaps his incentive is gone. Perhaps he feels that he is losing the important position he formerly held in medical practice.

In the April issue of the JOURNAL appeared a letter from one of our members entitled "The Need for a General Practitioners' Section in the Connecticut State Medical Society." As the writer of that letter states, such a section is now operating in Westchester County, New York, and in Wayne County, Michigan. To many the organization of a society (or section) representative of a majority of medical men will seem a confession of failure on the part of the parent organization to serve the interests of the majority. This may be true of our Society, you are the one to judge. There is a need for more general practitioners today and there will be the same need tomorrow. They must be trained and afforded a place in our hospitals and in our medical societies. They must have opportunities to meet on common ground and discuss their own problems as do the specialists. If such is the case some move must be made to encourage and support them. Some suggest a general practitioner on each specialty board;

others, a general practitioners' board. It is proposed to form a General Practitioners' Section within our State Medical Society at the annual meeting in Bridgeport. Doctor Arthur B. Landry, President of the Society, will preside at the organization meeting and as the speaker Mr. James E. Bryan, Executive Secretary of the Medical Society of the County of Westchester (N. Y.) has been secured. Are you interested in it? If so, let yourself be heard.

Compulsory Health Insurance

It is not infrequently that an idea becomes a phrase and the phrase a slogan, which for good or bad serves as a cloak to mask the original thought. Such is the case with "Compulsory Health Insurance," for like the "Holy Roman Empire" which as one has said was neither holy nor Roman nor an empire, "compulsory" in relation to health is misleading, "health" as modifying insurance inaccurate, and "insurance" itself to a great extent a misuse of the word.

The compulsory component is primarily related to the raising of the monies to carry out the project. A levy is to be made upon the employees' wages and upon the employers' expenditures for labor, these being supplemented by a subsidy from the government. The first is an income tax in the lower brackets up to now untouched, the second, a direct tax on the expense of labor in carrying on a business, and the last, the use of monies obtained by many forms of taxation.

The use of these funds so raised is also compulsory in the sense that they are to be applied to "health insurance," analogous to the procedure well established in the matter of the gasoline and motor tax and the construction and maintenance of highways. If there should be included in this latter program, coverage for injuries sustained by accident upon the highways, the situation would become more closely analogous but even then the caption "compulsory highway safety insurance" would scarcely be appropriate, though making an excellent slogan for promulgation.

The adjective "health" in the phrase is equally deceptive, for when associated with insurance it implies an assurance of the maintenance of a state of good health, and when modified by the accompanying "compulsory" one might expect a guarantee of this happy state. The program provides in theory (1) for the prevention of disease and (2) for the

care of the ill, which may or may not be more effectively provided than by methods now employed for these purposes. Certainly it offers no assurance aside from the one that the costs will be covered from monies derived from taxation.

Lastly, the word "insurance" has many facets of meaning so that it may be easily used with one and interpreted as having another, thus giving rise intentionally or otherwise to misunderstanding. Originally it was devised to ensure one against loss by a catastrophic occurrence such as death, fire, or the loss of a ship, and it still carries with it this concept of a protective value, even though the coverage in some instances is such that the supposed protection against loss is in reality a capitalization of a possible gain. Thus one may guard against living too long by annuity or "paid-up" insurance as well as against dying too soon by "straight life" insurance. Whatever the extension of the field, however, insurance is only sound where the gain of obtaining recompense is balanced by a penalty sufficient to discourage the wilful incurrence of it. Thus policies are written, excluding for a time, at least, suicide and the criminal law is peculiarly severe in respect to arson and barratry.

These variants are cited to illustrate the point that a promise of insurance is not sufficient. One has to know exactly how it is to be applied in the situations involved. In "compulsory health insurance" the desirability of prevention of disease must be sold, much as it is now, for experience has shown that the provision of the service free of a direct cost is in itself not a sufficient inducement for its general application. The provision of domiciliary and ambulatory medical care does not contain within itself sufficient penalties to prevent abuse and is, therefore, not sound insurance, although it may or may not be a proper expenditure of tax funds. Likewise care in an institution may or may not be sound from the insurance viewpoint, depending upon the presence or absence of a sufficient penalty to avoid unnecessary hospitalization.

The whole problem of the prevention of disease and the care of the sick would be approached more clearly if proposals made were not masked by the slogan "Compulsory Health Insurance," but rather have the title, "A Proposal for the Prevention of Disease and the Care of the Sick, the Costs of Which Are to be Met by Taxation."

S. C. H.

The Eagle and Its Prey

To those who expected little from the indictment of the American Medical Association and the Medical Society of the District of Columbia by the Federal Government, the recent trial must have come as a shock. Still more disturbing must have been the verdict rendered following the jury's finding of guilty of violating the Sherman Anti-Trust Law. In this day of intensive preparations for national defense, when thousands of physicians are giving freely of their time examining draftees with no thought of compensation, the trial at Washington can produce very little good will within the medical profession. In fact, the draining of the finances of our parent organization to uphold its rights at the trial reminds one of that Russian bear, Joseph Stalin, who sits quietly by while the life blood of others is being sapped. If Thurman Arnold had tried to select a better method of discouraging organized medicine in its attempts to solve the problem of improved medical care, he scarcely could have succeeded any better. Yet in spite of the rustle of the eagle's wings as it swoops down upon the unsuspecting physician, organized medicine will continue in its endeavors to find the most satisfactory plans for improving the quality as well as the quantity of medical care. The inference might be aptly drawn at this stage in federal proceedings that, had the medical profession been organized into unions since it is now said to be a trade, the Attorney General would have been obliged to pass by on the other side and find other fields for his perigrinations.

An editorial in the Meriden Morning Record gives an excellent resumé of the indictment with comment characteristic of the attitude of the press, at least in New England. We are pleased to reproduce this editorial in full.

THAT MEDICAL SOCIETY VERDICT

A jury in the United States district court in Washington last week rendered a guilty verdict in the case of the United States against the American Medical association, the Washington Medical society, and acquitted eighteen individual leaders of the medical profession in this country. It is stated that the verdict will be appealed to the Supreme Court. The legal course of the dispute between the defendants and the government has been long and hotly contested.

In 1939 Thurman Arnold, deputy attorney general, acting for the United States government, indicated the American Medical association, the Washington Medical association, the Harris County Medical Association of Texas, the Washington Academy of Surgery and twenty-one individuals associated with the above societies. The charges were for violation of the Sherman anti-trust act in that the defendants

entered into a conspiracy in restraint of trade. In that year the defendants entered a demurrer claiming that they were members of a learned profession and that medical practice was not a trade, within the meaning of the act.

Mr. Justice J. M. Proctor, of the United State District court, upheld the claim of the defendants. The government took an appeal and the court of appeals reversed the judgment of Justice Proctor. The defendants appealed to the Supreme court and the court refused to review the decision of the Court of Appeals. The case was returned to the district court for a trial.

In the trial it developed that a group of employees of the Home Owners Loan corporation borrowed \$40,000 from the Home Owners Loan corporation to start a group of physicians to care for them medically and surgically. This was to be paid for on a repayment basis by the subscribers for their professional care.

For many years the American Medical association has set up certain standards required of hospitals for the care of the patients and the training of young doctors. These are known as "the essentials for an approved hospital and for a hospital approved for the training of internes." Both standards are high and difficult of attainment, the second, of course, more rigid than the first. Included in these essentials is an appraisal of the professional caliber of the visiting physicians and surgeons. The group physicians made application for permission to operate or care for their subscribers in several Washington hospitals. This was denied them.

The government maintained that a conspiracy existed between the defendants and the Washington hospitals. At the close of the government's case, the defendants moved for an acquittal. This was granted in the cases of the Washington Academy of Surgery, the Harris County Medical society and two of the individual defendants. One of the defendants had died prior to the trial. After submission of the defendants' case the jury found the defendants guilty.

The case will, of course, eventually go to the Supreme court. Until then uncertainty will prevail. It may be that the days of so-called closed staffs in hospitals are over. It is possible that hospitals will not be permitted to evaluate their staffs and that anyone licensed to practice the healing arts will be permitted to practice medicine and surgery in our hospitals without discrimination, rules or discipline. Physicians and hospital executives interviewed feel that for the proper and adequate care of the patient it is necessary to adopt stringent rules and regulations governing hospital staffs.

The medical profession admits the necessity of some sort of medical insurance for people in lower income brackets. Many such plans are now being studied by several state medical societies. It is reported that the Connecticut State Medical society has a committee of prominent medical men now making such a study and that a report will soon be made recommending some such plan.

Whatever the outcome, it is to be hoped that, especially in these critical times when its services are so vital to national defense, the medical profession will not be subjected to the handicap of ill considered action by the government.

Care should be taken that in efforts to remedy certain defects a fertile field be not left open to politically-minded

bureaucrats or legislators. It would seem to be the part of wisdom to permit remedial action to come from within the medical profession itself.

The Annual Physical Examination

The annual physical examination appears to lack the support of the medical profession as a whole. Just why this should be true is difficult to understand, yet like it or not the demand by the public for a thorough complete physical examination is increasing yearly. In 1934 the State Medical Society expressed itself as in favor of such examinations and made available, free of charge, to the physicians of the state reminder cards, and history and physical examination forms. This met with very little support from the physicians throughout the state.

Can it be that this lack of support is due in part to a tendency on the part of the profession to avoid taking the time and trouble to take a detailed history and perform a complete examination? In many cases this would appear to be true. In the cancer program in this state statistics are being accumulated which would indicate two things. First, that many obvious external cancers are being missed due to the fact that a careful physical examination has never been made on the patient. Second, that patients consulting their family physician for a "health" examination are given a pat on the back and told that they never looked better in their life and to forget it.

More and more the public is being educated to believe in the annual physical examination as a means of staying well. The newly formed Woman's Field Army of the American Society for the Control of Cancer in Connecticut will shortly start their drive for membership. They are carrying on an educational program that advises the individual to see her doctor at the first sign of any abnormality, and also advocates the annual physical examination by a competent physician as a means of discovering still earlier cancer or precancerous conditions.

This is a challenge. Certainly we of the medical profession wish to retain our patients and their confidence in our competence as individuals to obtain a detailed history and make a complete physical examination. Certainly one factor in the increasing development of the clinic idea as an answer to the health examination has been the apparent lack of enthusiasm by the physician to completely study his patient. The answer would seem to lie in having the physician give a complete examination to all new patients, especially those over the age of forty, and

to answer the demand for annual health examinations with the delivery of what the patients ask—an adequate history and physical examination. It would seem to be much easier to educate the patient to pay a fee commensurate with the time entailed than to prevail upon many in the medical profession to render this service.

In an attempt to aid this program the State Tumor Committee is developing a new history and physical examination form which will be available shortly at the State Department of Health in two sizes, the 5" x 8" card, and the regular note paper size. These blanks may be used for all patients. It is the hope of the committee in furnishing these blanks that we may not only find earlier cancer but also discover many other abnormalities and unsuspected diseases that may be amenable to treatment.

P. G. McL.

Puberty, Adolescence and the Pediatricist

New Haven played host to the American Academy of Pediatrics during the closing days of March. The sessions which were held in the Sterling Law Buildings at Yale did credit to this organization founded but half a score of years ago. In particular those speakers who presented papers on "Certain Problems of Puberty and Adolescence" are to be commended for the wisdom of their counsel in the treatment of this decade of life. It seems altogether rational, as Doctor Lawrence K. Frank of the Josiah Macy, Jr. Foundation proposed, that the pediatricist should serve as the medical advisor to the child until the latter has reached maturity. Who better can understand the problems of adolescence and puberty than the physician who has started with the individual from scratch, as it were? It might even suggest itself to some that this second decade of life offers a sufficiently comprehensive and complex field as to occupy the sole efforts of a special group, call them what one will.

The underlying theme of the papers presented in this particular symposium, viz., that so many of the deviations from the norm in growing children during the second decade are but expressions of a change in rate of development, is most refreshing in this day of the hormone therapy barrage. As one of the speakers emphasized, obesity does not call

for the administration of a series of glandular products but may be but the evidence of a delay in development or an evidence of dietary over indulgences and as such requires little more than patience, diet and a good hygienic regimen. The administration of hormones with a few exceptions has little to offer in puberty and adolescence. It is far more important that a careful study be made of all the factors contributing to the problem,—physiological, psychic, hereditary—than that the latest hormone preparation at hand be utilized at no small expense to the patient and his family, perchance some good may result. The JOURNAL congratulates Region I of the Academy of Pediatrics. Connecticut medicine is the better for such gatherings within its borders.

Good Blood

In January, after a spirited contest, the State of New Hampshire inaugurated Doctor Robert O. Blood as its Governor. That shrewd Yankee State traditionally breeds physician statesmen who are willing to take a place in public affairs. Doctor Josiah Bartlett was the first to sign the Declaration of Independence after John Hancock; Jacob Gallinger was a picturesque figure in the United States Senate for a generation; John Gile was an advisor of governors and government for years but sought no elective office—and now a doctor Governor.

It was fortune to have known Bob Blood when he was an undergraduate, a quiet, studious young man, working his way. Later he was a soldier with a D. S. C., then a busy surgeon, a State Senator and leader of the Senate. Now he is Governor.

Some time when we think we are too busy to attend a committee meeting or do an extra-curricular job this Governor of New Hampshire may be an inspiration.

Erratum

In the editorial appearing in the April number of the JOURNAL entitled "The Warren Prize Comes to Connecticut" credit was given to Doctor Ebbe Hoff as being one of the recipients of the prize with Doctor Nahum. This was an error as the co-recipient was Doctor Hebbel E. Hoff. Our apologies to the latter gentleman.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

NEW HAVEN

Society Gains 36 Members in 1940

During the year 1940, the first year of increased dues the Society showed a net gain of thirty-six members. Only one County Association had a loss. The efforts of the special Membership Committee of the Fairfield County Association were productive and the County showed the largest membership increase.

Membership Changes During 1940

Fairfield County

Membership January 1, 1940	368
new members	38
	406

died	4
lost by resignation, transfer, dropped	
non-payment	13 17

Membership December 31, 1940	389
------------------------------------	-----

Hartford County

Membership January 1, 1940	532
new members	22
	554

died	4
lost by resignation, transfer, dropped	
non-payment	13 17

Membership December 31, 1940	537
------------------------------------	-----

Litchfield County

Membership January 1, 1940	75
new members	4
	79

died	1
lost by resignation, transfer, dropped	
non-payment	1 2

Membership December 31, 1940	77
------------------------------------	----

Middlesex County

Membership January 1, 1940	65
new members	7
	72

died	2
lost by resignation, transfer, dropped	
non-payment	3 5

Membership December 31, 1940	67
------------------------------------	----

New Haven County

Membership January 1, 1940	510
new members	43
	553

died	9
lost by resignation, transfer, dropped	
non-payment	29 38
	38

Membership, December 31, 1940	515
-------------------------------------	-----

New London County

Membership January 1, 1940	116
new members	7
	123

died	
lost by resignation, transfer, dropped	
non-payment	9 9

Membership December 31, 1940	114
------------------------------------	-----

Tolland County

Membership January 1, 1940	17
new members	3
	20

died	
lost by resignation, transfer, dropped	
non-payment	0

Membership December 31, 1940	20
------------------------------------	----

Windham County

Membership January 1, 1940	40
new members	2
	—
	42
died	1
lost by resignation, transfer, dropped	
non-payment	1 2
	— —
Membership December 31, 1940	40
	—

Totals

Fairfield	389	
Hartford	537	
Litchfield	77	NET GAIN FOR YEAR 36
Middlesex	67	
New Haven	515	
New London	114	
Tolland	20	
Windham	40	
	—	
	1759	

Deaths 1940

George W. Hawley, Westport, January 1
 John J. Cloonan, Stamford, January 28
 H. LeBaron Peters, Bridgeport, August 1
 Leo Wilson, Stamford, October 13
 George W. May, South Manchester, October 23
 John F. Lynch, Hartford, September 2
 Jacob T. Woodson, Hartford, November 9
 Thomas F. Maher, Newington, December 18
 Timothy M. Ryan, Torrington, December 16
 Daniel A. Nolan, Middletown, August 6
 Arthur B. Coleburn, Norwalk, November 5
 Henry L. Swain, New Haven, January 12
 George S. Whiteside, New York City, January 29
 Raynham Townshend, New Haven, January 31
 James S. Maher, New Haven, June 7
 Nelson A. Ludington, New Haven, June 26
 Leslie A. Wilson, Meriden, March 15
 Harry B. Ferris, New Haven, October 12
 Oliver T. Osborne, New Haven, November 11
 John C. Lindsay, Cheshire, November 15
 Bernard P. Murphy, Putnam, December 14
 William J. Scott, Derby, December 3

Resignations 1940

Daniel D. Lovelace, Danbury
 Athens N. Grant, Stamford (suspended)
 Donald R. MacLean, Stamford
 John A. P. Millett, New York City
 George Y. Smith, Bridgeport
 Joseph G. Pekala, Northampton, Mass.
 Curtis T. Prout, Arlington Heights, Mass.
 Harry A. Seigall, Hartford
 Mabel E. Curtiss, Bristol
 Nathaniel E. Gourson, Maywood, California
 Lewis I. Sharp, New York City
 Philip M. Cornwell, East Hartford
 Warren Whitford, Windsor Locks
 Milton L. Marsh, New Britain
 Maurice D. Spottswood, Hartford
 George L. Wadsworth, Howard, R. I.
 Isabella Cowan, Waterbury
 Daniel J. Maloney, Waterbury
 Edward B. Speir, New Haven
 Phillip J. Cantor, Norwich
 Louise W. F. Wilson, England
 Joseph Weiner, New Haven
 Albert E. Harrington, Chicago
 Max Blum, New Haven
 John J. MacDonald, Milford
 Thomas B. Murphy, Wallingford
 Frank J. Hill, Waterbury
 Monroe J. Tanner, New Haven

Transferred 1940

DeWitt Dominick, Bridgeport to Wyoming
 Orin R. Yost, Hartford to Ohio
 Oliver L. Martin, Hartford to Kansas
 Anna Colomb, Philadelphia to Pennsylvania
 Ernest F. Gordon, Yonkers to New York
 Jerry S. Bell, Brooklyn to New York
 Edgar VanN. Emery, St. Louis to Missouri
 Clarence H. Cole, New Haven to Pennsylvania
 Dropped non-payment of dues 28

Only the most rigid contagious disease technic provides a barrier and prevents the spread of tubercle bacilli from hospital patient to student nurse. J. A. Myers, M.D., et al., Annals Intern. Med., Nov. 1940.

THE CONNECTICUT HOSPITAL ASSOCIATION

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WILLIAM B. SWEENEY, Secretary

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HELEN NIVISON, Treasurer

Bristol Hospital

The Bristol Hospital management has found that the equipping of a hospital library has been much appreciated and a great deal of pleasure has been given the patients by this type of service.

The total number of books at the Hospital for the use of the patients is about 700, half of this number being Public Library books, and the remainder the property of the Hospital. Three-fourths of the books are for adult readers, and the rest for the children.

Since the beginning of the Hospital library service in May 1937, 1150 borrowers' cards have been issued at the Hospital, most of them to patients, but some of the nurses have availed themselves of Library privileges.

During the past year 2,718 books have been issued including 2,491 adult and 227 juvenile. As to the value of the service rendered, may I quote, with approval, the following from the first report of library service included in the Hospital report for 1937. "The result of library service at the Hospital, numerically, in number of books exchanged, is not so great—but numbers are not a criterion of the solace and comfort given at the hospital, voiced by appreciative patients. Personal experience enables me to attest the worthwhileness of our hospital library service."

The circulation is small as compared with the number of books issued at the Public Library or at its various school branches. However, the manner in which the patients anticipate the arrival of the book truck, and the joy with which it is received, makes the rendering of the service a pleasure rather than a duty.

Clinical Conferences at the Bristol Hospital

The Bristol Hospital is a relatively young hospital, so we have no long-standing traditions. This has advantages as well as disadvantages. It has enabled us to develop freely by a process of trial and error to meet the needs of the community of 35,000 in-

habitants, with thirty-five physicians, most of them general practitioners doing varying amounts of surgery. The problem has been how to run our clinical conferences in a community hospital of 100 beds. These principles have been followed:

1. The conferences are run primarily for the general profession of the city, whether or not they are members of the staff. Anyone is invited to present a case.
2. Whenever possible cases are seen in person. A case which has been seen is remembered much longer than if it were read about.
3. Those doctors who do surgery ought to see medical cases and those who do medicine chiefly should see surgical cases, for the general practitioners are the ones who are called on to diagnose surgical conditions in the early stages. So each program should show both medical and surgical cases.
4. Cases are presented from outside the hospital as well as in and occasionally a visitor will bring in a rare case from out of town.
5. Private cases as well as ward cases are shown, thus getting away from an experience made up of cases drawn from the lower income groups only.
6. All meetings are started promptly on the hour so that those coming early will not have to waste their time, and they are concluded promptly at the end of the hour.
7. Each man attending a conference is in turn invited to join in the discussion, whether or not he is on the staff.

Half in fun and half in earnest the conferences have been dubbed "The Little Postgraduate School of Medicine."

Last year we had 42 meetings with an average attendance of nearly 50 per cent of the Bristol doctors.

The above plan probably would not be fitted to a large city or a large hospital, but it works exceedingly well here.



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Charlotte Hungerford Hospital

In the death of John Norton Brooks, the Charlotte Hungerford Hospital lost one of its original Corporators. Mr. Brooks who was 71 years of age died April 7 at his home in Goshen. Doctor Harry B. Hanchett, Medical Examiner, attributed his death to heart failure. Mr. Brooks was one of Torrington's most prominent citizens. Among the many offices which he held were Burgess of the Borough, Town Treasurer for many years and the first Treasurer of the City after it was incorporated. He served in the Connecticut Legislature from 1915 to 1925, one term in the Lower House and four in the Senate from the 30th district. While a member of the Senate, he was Chairman of the Committees on Banking and Military Affairs. He was President of the Brooks Bank and Trust Company, the Torrington Savings Bank, the Torrington Water Company, insurance firm of Brooks & McNeil and the Torrington Library. He was Vice-President of the Torrington Printing Company, the Torrington Electric Light Company and Treasurer of the Warrenton Woolen Company. Funeral services were held from his home in Goshen on April 10 and were conducted by the Rev. G. Homer Lane, Pastor of the Central Congregational Church, Torrington. The body was sent to Springfield, Mass., for cremation.

The Registered Nurses Club held its monthly meeting on April 8 in the Auditorium of the Charlotte Hungerford Hospital. The speaker was Doctor Gilbert Hubert who chose for his subject, "The Use of Vitamin B in Pediatrics." This Club has decided to sponsor an Advance Course in First Aid for members of their organization. Doctor Louis E. Garston will serve as instructor.

Middlesex Hospital, Middletown

The employees of this institution have organized a Safety Council. The purpose of the Council is to reduce fire and accident hazards in the Hospital. The Council is composed of representatives from each department. The Superintendent and the Chief Engineer listen in. The Council meets during working hours, the last Thursday of each month for one half hour. During the previous month each representative has made rounds of his department with the department head to look for hazards. If any are discovered they are reported at the next meeting and they are considered in detail that they may be eliminated. The Council also studies accidents which

have occurred during the previous month. Occasionally one member of the Council is asked to make a report on a topic concerning safety. The most recent safety magazines are subscribed to and help has been secured from the Bacon Library. The Council has written its own by-laws and elected its officers consisting of a Chairman, Vice-chairman and Secretary which is known as the Executive Committee. We have noticed a decided improvement in the employee's awareness of accident hazards since the Council was organized.

The Hospital Auxiliary has been reorganized and is now sponsoring a student nurse three year scholarship. The funds for the scholarship will be secured from a county wide dance to be held May 1 and known as the May Day Ball.

The uniforms of the office personnel have been changed from blue smocks to black skirts and white silk blouses.

Waterbury Hospital

A meeting was held recently in Waterbury at which representatives from the various women's organizations, clubs, charitable institutions, etc., were in attendance. This is similar to a program sponsored by the Junior League of New York City, the purpose being to register and classify all available workers in case of sabotage or any local catastrophe. The outline of the program is presented herewith.

1. Purpose.

The purpose of such a bureau is to coördinate and organize volunteer service so that the essential social and health services in the city may be maintained in time of emergency and that additional services necessitated by the defense program shall be effectively carried on.

2. Functions.

1) To recruit and organize women desirous of serving their country, in order that their individual contributions may be of maximum benefit. To point out to women that some of the most effective service which can be given will be volunteer participation in the usual community agencies.

2) To coördinate the work of volunteers by serving as a source of information on all volunteer opportunities, offering guidance to applying volunteers and placing them in jobs for which their individual interests and abilities qualify them.

- 3) To coördinate the various training courses given by organizations in order to avoid duplication.
- 4) To supplement and complement the services of paid workers.
- 5) To improve the quality of volunteer work.

3. Organization.

Under the Executive Committee, the following sub-committees are suggested:

- 1) Committee to study community needs and resources;
- 2) Committee to carry out program of interpretation to the community (Publicity);
- 3) Committee to recruit volunteers;
This may be done by city-wide registration or by recruiting volunteers from different organizations who are sponsoring members of Women's Committee.
- 4) Committee on training of volunteers;
- 5) Committee for interviewing and placement of volunteers.

4. Staff.

While the ideal set-up for such a Bureau is to have a paid worker who will act as Executive Secretary, it is possible to run such a bureau through volunteer effort. It is extremely important that those who undertake interviewing and placement have the ability to inspire confidence in both professional and lay people, as well as some experience, either professional or volunteer, in personnel procedure.

Secretarial help, either paid or volunteer, will be necessary for keeping files of volunteer opportunities and records of individual placements.

5. Physical Equipment and Budget.

The Bureau would not need elaborate quarters, but space for record files should be provided, and separate rooms for interviewing is possible. Necessary funds may be obtained from organizations participating. Unless a paid worker is employed, the amount needed from each organization should not be large.

Nominations may be sent to Mr. Finton Phelan, 76 Center Street. Mr. Phelan is Acting Chairman of the Mayor's Defense Committee.

National Hospital Day

Harry C. Smith of the Manchester Memorial Hospital and State Chairman of the National Hospital Day Committee writes as follows:

To date, all administrators within the State have received the booklet HOW AND WHY. Should they wish additional copies or a second booklet, PRESSING FORWARD, they may be obtained from Mr. Albert G. Hahn, Deaconess Hospital, Evansville, Indiana.

The Fairfield State Hospital will observe Sunday, May 11, as a week day is inconvenient for relatives of patients. Also, Sunday is a major visiting day.

Editor's Note: It is to be hoped that every hospital will secure a wider observance of Hospital Day this year than ever before because public attention is at present more focused on our hospitals than ever before. The Plan for Hospital Care has done much to make people more hospital minded. The increase of patients has tended to bring to the attention of the public generally the lack of adequate hospital facilities in many of our communities. The development of our plans for medical defense are, in a very large measure, centered around our hospitals. It would seem, therefore, that all of our hospital administrators should take advantage of this opportunity to more intimately acquaint the public with the activities and administration of their institutions.

Wanted by State Police

We quote an excerpt from a letter to Mr. William B. Sweeney from the State Police Department, Beacon Falls, Connecticut.

I am wondering if you can be of some assistance to us in locating one James Connelly, age 27, originally coming from Boston, Massachusetts, six feet tall and weighing 165 lbs; long thin face with a small moustache and false teeth.

His last place of employment was the Laurel Heights Sanitarium in Shelton, and while working at this place he stole somewhere in the neighborhood of \$40.00 and owes several of the patients there also. Prior to that he worked at the Grace Hospital in New Haven, and we further learned that he skipped out without paying his room rent at the place where he was rooming, and also stole a radio there. He is wanted by us on the charge of theft and embezzlement.

While at the Laurel Heights Sanitarium he worked as an orderly, as he did also at the Grace Hospital. We are of the opinion that he will seek similar employment in another hospital. If such is

the case, we may be able to apprehend this fellow through your literature or bulletin.

If there is anything that you can do, we will appreciate it.

Sincerely yours,

Lieutenant Wm. L. Schatzman, c.o.

Beacon Falls Barracks

Beacon Falls, Connecticut.

The National Executive Housekeepers Association of America

Of special interest to the hospitals of Connecticut is the organization of a local or state chapter of the National Executive Housekeepers Association of America, Inc.

Membership is open to housekeepers connected with hospitals, a number of whom have already affiliated with this chapter. Other members are women housekeepers with executive duties and responsibilities in hotels, clubs, schools, private and state institutions, steamships, railroads, etc.

The purpose of the organization is to encourage a better understanding of institutional housekeeping through research, educational films and exhibits, selected reading, qualified guest speakers, and round table discussions devoted to an exchange of ideas and information.

While the membership is still comparatively small in the Connecticut chapter, it is growing more rapidly as women in these positions learn of it and realize the value to be derived from such a movement.

Miss Evelyn L. Coolidge, Director of Housekeeping at the New Haven Hospital, is president. The Chapter is fortunate in having as a member Mrs. Doris Dungan, Director of Housekeeping at Hartford Hospital, Hartford, who is also president of the national organization.

The Connecticut Chapter meets monthly in some one of the cities throughout the state and often has the privilege of having as a visitor Mrs. Grace Brigham of the Providence Biltmore Hotel, Providence, R. I., a past president of the national organization.

After Surgery, What?

After the orthopedic surgeon has completed the necessary operation or operations on the case, what then for these patients that are turned out of the hospital or clinic? What treatments are given to rehabilitate these cases back into their places in society? In the city of Bridgeport there has been functioning for the past five years a Crippled Childrens' Clinic, where children can receive physical therapy training and clinical check-ups. But even the clinic program was not sufficient enough to bridge the gap of post-hospitalization to that of the normal routine. In many cases such as the cerebral palsy child, it was not complete enough inasmuch as there was needed assistance in providing an educational program for the patient and the family too. In cases that are permanently disabled through surgical amputation, infantile paralysis, congenital deformities and through many other orthopedic sources, there is need for immediate attention to provide relief during the "shock" period of facing their adjustment to a normal set-up of activities. Theirs is the need of a supervised occupational period to bring back active movement into their impaired muscles and joints; and too, to provide through a re-education program the methods of utilizing their impaired skills to the best advantages, or to improvise new methods of work in place of their former habits.

So often there are more apparent methods of obtaining and providing for the surgical, pathological, metabolic or physiological detail and which should rightly receive precedence; but then, too very often with the above findings completed the individual is discharged without the mere mentioning of the sociological adjustment which must take place in order for the individual to resume or make a niche for himself in society. Therefore, in order to insure the work of the orthopedic surgeon and to accomplish the greatest amount of rehabilitation for the patient, it is of the utmost importance to provide a complete follow-up program after the period of hospitalization and surgery is completed. This pro-

(Concluded on page 362)

YOU ASKED FOR IT: — The Professional Equipment Company of New Haven announces that they have a new Taylor Pavaex "glass boot" available for rent. This service was instigated at the request of several doctors who have seen the apparatus used very successfully in many cases of arteriosclerosis obliterans, acute arterial occlusion, peripheral circulatory stasis, etc. Immediate delivery anywhere in Connecticut.

(SEE PAGE 2)

MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
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GEORGE M. SMITH, M.D., State Chairman, 258 Church Street, New Haven, Conn.

Connecticut Physicians Ordered to Active Duty

- Joseph J. Bruno, New Haven.
- *Louis F. Castaldo, Bridgeport.
- Ralph E. Costanzo, Stamford.
- *Francis L. DePasquale, Hartford.
- *A. Elmer Diskan, Manchester.
- Neshon E. Dorian, New Britain.
- *Leo T. Duffy, Hartford.
- *Francis Gallo, Winsted.
- Lester A. Joseph, New Haven.
- *Joseph J. Lankin, Hartford.
- Sidney E. Maislen, Hartford.
- James E. Mazzacane, Hamden.
- *Paul L. Phillips, Hartford.
- Norman E. Robinson, Waterbury.
- *John J. Scanlon, South Norwalk.
- *Lloyd M. Wilcox, Terryville.

Previous Order Revoked

- *C. Seaver Smith, New Haven.
- *Members Connecticut State Medical Society.

Changes in Selective Service Organization

New Haven Advisory Board

- William H. J. O'Brien, New Haven, added as consultant in ophthalmology.
- Clarence L. Robbins, New Haven, added as consultant in internal medicine.
- Ashley W. Oughterson, New Haven, added as consultant in surgery.

Hartford Advisory Board

- Charles T. Bingham, Hartford, added as consultant in internal medicine.

Fairfield County Advisory Board

- Newell W. Giles, Stamford, added as consultant in ophthalmology.
- John A. McCreery, Greenwich, added as consultant in surgery.

Army Induction Board

The Army Induction Board which works at the Induction Center in Hartford is the final examining board that accepts and inducts recruits into the Army. This Board was organized and its operation has been continued under the direction of Doctor Donald B. Wells, Chairman on Medical Preparedness for Hartford County.

The Board consists of specialists in the various fields of Medicine and varies in number from day to day depending upon the number of enrollees who are sent from local examining boards to the Induction Center. It is not necessary for the Board to work all of the time, but during the periods of induction separate boards work on alternate days, and with a board consisting of thirteen members it is possible to process three hundred candidates in one day.

The Board starts its operations early in the morning and continues through the day or until that day's induction has been completed. Because of convenience, the physicians serving on the Induction Board have been largely recruited from Hartford and the immediate vicinity. From time to time changes have had to be made in the personnel of the Board because of illness or vacations.

Following is a list of examiners who have served on the Induction Board in some or all of the induction periods from November 1940 to date. These are grouped according to specialties. The arrangement of names is alphabetical and does not indicate relative seniority.

INTERNISTS

- Apter, Harry, M.D., Hartford
- Bingham, Charles T., M.D., Hartford
- Clancy, John J., M.D., Hartford
- Felty, A. R., M.D., Hartford
- Hollinshead, Joseph B., M.D., West Hartford
- Jenovese, Joseph F., M.D., Hartford
- Lowell, W. Holbrook, M.D., Hartford

McCue, Martin P., M.D., Hartford
 Sullivan, Arthur B., M.D., West Hartford
 Twaddle, Paul H., M.D., Hartford
 Warren, H. Stanley, M.D., Wethersfield
 Durkee, Ralph E., M.D., Hartford

NEUROPSYCHIATRISTS

Farland, Victor L., M.D., Hartford
 Gold, Louis H., M.D., Hartford
 Riendeau, Fernand M., M.D., Torrington
 Wiedman, Otto G., M.D., Hartford

OPHTHALMOLOGISTS

Birge, Henry L., M.D., Hartford
 Cunningham, John C., M.D., Hartford
 Unsworth, Arthur C., M.D., Hartford

OTORHINOLARYNGOLOGISTS

Harris, Louis D., M.D., Hartford
 Neidlinger, William A., M.D., Hartford

EYE-EAR-NOSE-THROAT EXAMINERS

Montano, Rocco A., M.D., Hartford
 Samponaro, Nick, M.D., Hartford

SURGEONS

Lampson, R. Starr, M.D., Hartford
 Osmond, Robert H., M.D., Hartford
 Quarrier, Sidney S., M.D., Hartford
 Standish, Welles A., M.D., Hartford

ORTHOPEDISTS

Crosby, Edward H., M.D., Hartford
 Sneiderman, George I., M.D., Hartford
 Galinsky, David, M.D., Hartford

PATHOLOGISTS

Coll, James J., M.D., Hartford Hospital
 Humphrey, Henry D., M.D., Hartford Hospital

DENTISTS

Daniels, Frederick C., D.D.S., Waterbury
 O'Hara, Mortimer A., D.D.S., Waterbury

Exemption From Military Duty for Medical Students, Interns and Residents

The United States Senate Military Affairs Committee held hearings on S. 783, the Murray Bill, March 18, 19 and 20. Representatives of numerous organizations appeared before the Committee and stressed the desirability of conserving the medical resources of the country, the apparent objective of the bill. Opinions differed as to whether a law should be enacted providing for blanket deferment and concerning the particular phraseology used in the Murray bill.

Representatives of the War Department General Staff and of the Selective Service System appeared in opposition to the enactment of the bill on the ground not that the objective was undesirable but that any such blanket deferment as contemplated would precipitate appeals from other groups for similar deferment and that much confusion would result. The witness who appeared for the Selective Service System said that efforts were being made to solve the problem administratively.

Among the Associations represented at the hearing were the American Medical Association, the American Hospital Association, the Catholic Hospital Association, the American Youth Congress, the Association of Medical Students and the Interne Council of America. A statement was presented, too, on behalf of the Committee on Preparedness of the Association of American Medical Colleges.

Representatives of other groups not embraced within the phraseology of the pending bill filed petitions with the Committee for a broadening of the base of the bill so as to include such groups. Such petitions were presented on behalf of the osteopaths, the chiropractors, the optometrists, the pharmacists, and the veterinarians.

H. R. 4184, introduced by Representative Flannery, Pennsylvania, March 26.—A bill to authorize the deferment under the Selective Training and Service Act of men engaged in the study of medicine. Pending in the House Committee on Military Affairs.

This bill proposes to amend the first sentence of section 5(e) of the Act to read as follows, the underscored words constituting the language to be added: "The President is authorized, under such rules and regulations as he may prescribe, to provide for the deferment from training and service under this Act in the land and naval forces of the United States of those men whose employment in industry, agriculture, or other occupations or employment, or whose activity in other endeavors, including the study of medicine, is found in accordance with section 10 (a) (2) to be necessary to the maintenance of the national health, safety, or interest."

"War Medicine, Vol. I, No. 2"

The second number of the American Medical Association's new by-monthly, WAR MEDICINE, contains much of interest. Russell M. Wilder, M.D., of Rochester, Minnesota, reports that a campaign

aimed at correcting the faulty diets of the American people is being planned as a part of the national defense program. This campaign is to be furthered through the various media of public information such as newspapers, magazines and radio and aims to educate the people on the proper selection of food. In the same issue the vital role that psychiatry will play in national defense, particularly as it applies to the armed forces, is pointed out in a symposium on the psychiatric aspects of military medicine. Three approaches to the problems involved are contained in the symposium: "The Army Medical Officer Looks at Psychiatry," by Colonel Samuel Adams Cohen of New York; "Psychiatric Examination in the Armed Forces," by Lieutenant Commander Karl M. Bowman of New York; and "The Neuroses of War," by Doctor A. Kardiner of New York.

John R. Poppen, M.D., Commander, Medical Corps, U. S. Navy, declares in a discussion of the "Influence of Aircraft Performance on Selection and Care of Military Aviators" that the performance of aircraft now exceeds the capabilities of normal human adaptability.

An editorial, "Preventing Venereal Disease," outlines preventive measures which have been taken in that field.

Perhaps one of the most entertaining articles in this number is that entitled "Medical Aspects of Submarine Rescue and Salvage Efforts" by Albert R. Behnke, M.D., Lieutenant, Medical Corps, U. S. Navy. Ever since Lieutenant Chrisman presented his paper on "Submarine Escape Training" before our State Medical Society in June 1938, followed by the contribution to the Medical Preparedness Number of the JOURNAL of "Medical Aspects of Deep Sea Diving" by Lieutenant Commander C. W. Shilling, our readers have been interested in this phase of medical practice. Lieutenant Commander Shilling's account of the rescue of the men from the Squalus will be remembered with considerable interest. The whole problem is brought up to date by Lieutenant Commander Behnke's discussion in WAR MEDICINE.

AFTER SURGERY WHAT?

(Continued from page 359)

gram should consist of a physical therapy program followed by a program of occupational therapy in an orthopedic workshop.

Without too much disturbance and fan-fare to the already existing medical program in Bridgeport, the Connecticut Society for Crippled Children under local supervision of the Bridgeport Chapter and representatives from the local Medical Society, the Bridgeport Crippled Children's Workshop was established for the existing orthopedic cases. It is meeting a two-fold problem in Bridgeport: (1) to help and to provide under medical guidance vocational training for the already existing chronic cases of crippling and to assist this group into re-adjusting themselves into becoming reliant and self-respecting citizens; (2) to maintain a curative occupational therapy program to prevent in the future and to reduce the load of crippled people without employment, and reduce maladjustment. It is the working plan to provide a complete program for the patient, following hospitalization through to occupational training and re-education to employment, or if the case is that of a younger person and not warranting employment, back into a school program. All orthopedic cases needing this service are admitted under prescription and medical recommendation of their physician. All cases before entering the workshop program are given psychological testings to determine their mental ability, aptitudes, and manual skills.

In addition to teaching types of activities that will utilize their impaired muscles and joints to develop and strengthen the weakened portions, our vocational rehabilitation program provides training in occupations and professions which the patient can carry on in spite of his physical limitations; it will thus provide for them the manner in which they can become self-supporting. For now, orthopedic cases can receive rehabilitation and retraining under the medical supervision through trained technicians.

GOT A MATCH? — You don't need to have, to test for urine sugar with the new "Galatest" method, which dispenses with the need for bunsen burner and other laboratory equipment. A single drop of urine on a few grains of Galatest powder instantly reveals the presence or absence of sugar. You will like it, doctor, and so will your nurse and diabetic patients. Price? Fifty cents for approximately one hundred tests. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2)

THE LEGISLATURE

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

BERKLEY M. PARMELEE
Bridgeport

D. C. Y. MOORE
S. Manchester

HARRY B. HANCHETT
Torrington

JOSEPH A. BEAUCHEMIN
Middletown

GEORGE BLUMER
A.M.A. Delegate

DAVID R. LYMAN
Wallingford

EDMUND L. DOUGLASS
Groton

RALPH B. THAYER
Somers

CECIL R. GARCIN
Danielson

JAMES R. MILLER
A.M.A. Delegate

ARTHUR B. LANDRY, President

CREIGHTON BARKER, *Executive Secretary*

Connecticut General Assembly

CANCER APPROPRIATION BILL PASSES

The bill appropriating \$25,000 a year for two years to the State Department of Health for cancer research and to assist the State tumor clinics, that was supported by the State Medical Society, has been passed by the House and Senate and awaits the Governor's signature to make it a law.

COMPULSORY AUTOMOBILE INSURANCE

The several bills that would establish compulsory automobile insurance, some of which included the operation of a State insurance fund, have all received unfavorable committee reports.

COMPULSORY WORKMEN'S COMPENSATION INSURANCE

The several bills aiming to establish compulsory compensation insurance in a state fund, some of which put the administration of the fund in the State Department of Labor and Factory Inspection, have all received unfavorable committee reports.

A BUREAU ON OCCUPATIONAL DISEASES AND INDUSTRIAL MEDICINE

The bills that would remove the Bureau on Occupational Diseases from the Health Department and establish a new Bureau in the Department of Labor and Factory Inspection have received unfavorable committee reports.

MENTAL HEALTH

Bills that would have established a State Department of Mental Health and a Council On Mental Health have received unfavorable reports from the Committee on State Administration. Identical bills were heard by the Committee on Humane Institutions and a report by that Committee has not yet been filed.

HEALTH INSURANCE

The model health insurance bill was heard by the Committee on State Administration and has not yet

been reported out. It is possible that a substitute bill calling for a State study of the necessity for compulsory health insurance may be reported.

COMMITMENT OF THE INSANE

The several bills revising present statutes concerning the commitment of insane persons have been heard by the Committee on the Judiciary. The Committee has not yet reported.

BLOOD AND URINE TESTS FOR ALCOHOL

The bills that would permit or require blood and urine tests from persons accused of drunken driving have been unfavorably reported.

CONTAGIOUS DISEASES

The bill requiring reporting names of all persons suffering from contagious diseases has been favorably reported by the Committee on Public Health and Safety.

THE MEDICAL PRACTICE ACTS

Hearings on the Society's bills to revise the Medical Practice Acts have been held before the Committee on Public Health and Safety. As yet the Committee has not filed its report.

CHIROPRACTIC

The several bills that would revise the statutes regulating the practice of chiropractic have all been unfavorably reported.

NARCOTICS

The bill amending certain sections of the Uniform Narcotic Drug Act of Connecticut that would restrict the dispensing of certain compounds containing minimal amounts of opium and derivatives has been unfavorably reported.

CREMATION

A bill requiring a certificate authorizing cremation to be signed by the medical examiner instead of the health officer has been favorably reported.

PRENATAL WASSERMAN

The Society's bill requiring a Wassermann test from each pregnant woman has been heard before the Committee on Public Health and Safety. The bill was amended by the Health Commissioner to add an appropriation of \$6000. The Committee has not yet reported on the bill.

SCHOOL HEALTH

The bills (4) which would revise the statutes concerning physical examination of school children and the keeping of records of the results of such examinations are reported to have been withdrawn.

STUDY OF CHRONICALLY SICK

The bill that would provide a Commission to

study the care of the chronically sick and recommend a public program for their care has been favorably reported by the Committee on Humane Institutions.

CHEMICAL AND MICROSCOPIC EXAMINATION OF DEAD BODIES

The Society's bill that would allow medical examiners to authorize chemical and microscopic examination of dead bodies was amended in the Committee on Public Health and Safety to require that such examinations be made in laboratories approved by the State Department of Health. The bill was favorably reported by the Committee on Public Health and Safety and has been referred to the Judiciary Committee.

THE PRACTICE OF MEDICINE BY OSTEOPATHS

Brief presented by The Connecticut State Medical Society in opposition to S. B. 519, An Act Concerning Osteopathy, at the hearing before the Committee on Public Health and Safety on April 15, 1941

What Is Osteopathy

OSTEOPATHY is not defined in the Connecticut statutes and the classical definitions of the practice are not always accepted by its devotees. The Encyclopaedia Britannica, 14th edition, states, "According to its advocates, osteopathy is a system of health and healing founded on the theory that the living body is a vital machine which will make the remedies necessary to protect itself against disease so long as it is in correct mechanical adjustment. In addition, osteopathy insists upon a wholesome physical and mental environment, good food, proper exercise and rest, and pure air and water." This definition is not a physicians definition or a layman's definition, but was written by Ray G. Hulburt, Director of Information and Statistics, American Osteopathic Association, Chicago, formerly Editor of Journal of Osteopathy.

The Congress of the United States has also defined osteopathy in Senate document No. 445 of the 59th Congress, first session, May 16, 1906. It reads, "Osteopathy is that system, science or method of healing which teaches that disease or perverted function is traceable to mechanical difficulties or abnormalities of the structure of the body mechanism and in the practice of which the correction of such

difficulties or abnormalities is sought to be accomplished by manual methods and without the internal administration of drugs or medicines."

It has been contended by osteopaths and some others that such definitions are outmoded, inappropriate and inadequate to describe modern osteopathy. However the Georgia courts have held within a year that osteopathy is, "a modern system or science of treating diseases by kneading and rubbing the body, a method of treatment of diseases of the human body without the use of drugs, by means of manipulations applied to various nerve centers, chiefly those along the spine, with a view to inducing the circulation of blood and lymph and the equal distribution of the nerve forces."

The Use Of Drugs By Osteopaths

Osteopathy was founded about 75 years ago by Doctor A. T. Still and throughout his lifetime Doctor Still was sharply opposed to the use of drugs by the devotees of his newly founded medical cult. "We have a friendly feeling for other non-drug natural methods of healing," wrote Doctor Still, "but we did not incorporate any other methods into our own system. We are opposed to drugs. We are opposed to the use of drugs as remedial agents; we are opposed to vaccines; we are opposed to the use of serums in the treatment of disease; nature furnishes its own serums if we know how to deliver them."

This earlier opinion of osteopathy and drugs is still held by prominent osteopaths. The 1935-1936

catalogue of the Des Moines School of Osteopathy printed, "Osteopathy was announced by Doctor A. T. Still in 1874. Since that time the treatment of disease has undergone many changes from what was considered scientific medical practice at that time. Osteopathy in principle has not changed."

In March 1937 George M. Laughlin, President of the Kirksville School of Osteopathy, is quoted in the *Journal of Osteopathy*. Doctor Laughlin said, "What I am chiefly alarmed about is the tendency of so many of our osteopathic practitioners to neglect the osteopathic therapy and to resort to the use of drugs about which they know little. These practitioners depend largely upon the directions upon the bottle for dosage of such drugs and their indications. Hundreds of concoctions are put out under trade names that are in wide use by osteopaths who are engaging in a practice not taught by the college here."

Doctor Laughlin went further to say, "Remember this, the reason people came to osteopathy and one of the principle elements in the establishment of the science is the rebellion of the people against drugs. We used to preach that a good deal; it made some friction, but it is a fact that osteopathy would never have been born and not have grown nor attained the size it has today as a profession if it were not for the fact that people got tired of taking medicine."

Schools Of Osteopathy

There are about a half dozen schools of osteopathy in America. These schools are all of a proprietary nature, that is, they are private enterprises not connected with any institution of higher learning. None of the great endowed or state universities in this country have found it necessary or desirable to establish departments in osteopathy.

The Teaching Of Therapeutics In Schools Of Osteopathy

Statements have been made that materia medica and therapeutics are now taught in schools of osteopathy in spite of the earlier statements that the practice of osteopathy did not need, and indeed looked askance upon the use of drugs. It is further said that the quality of instruction in materia medica and therapeutics in schools of osteopathy is equal to the quality of such instruction given in schools of medicine, and that graduates in osteopathy are as well trained in therapeutics as are medical graduates. This is a statement that is made by advocates of

osteopathy and that cannot be substantiated by the opinion of any unbiased observers. The schools of osteopathy have consistently refused to allow the Council on Medical Education and Hospitals, the American Hospital Association and the American College of Surgeons to inspect them and determine the quality of the instruction given. Medical schools in this country are periodically inspected and rated by the Council on Medical Education, and through this inspection the standard of medical education has been elevated to a point where it is superior to any other in the world. The schools of osteopathy have been unwilling to be viewed by this national body. Moreover, some other states when faced with proposed legislation similar to that now being considered in Connecticut, have sought to inspect schools of osteopathy with a view of determining if the instruction given therein was sufficient to qualify graduates to practice medicine within the state, have been confronted with opposition on the part of the osteopaths. Such a measure was lately pending before the legislature of the State of Oregon and was being vigorously opposed by the osteopathic profession.

Unless and until an unbiased valuation of the quality of instruction in therapeutics in these schools is available it is improper to accept a statement of the quality of instruction given by advocates of osteopathy.

In this connection the Tenth Circuit Court of Appeals in the State of Kansas has lately held, "in an osteopathic college the broad principles of medicine and surgery so investigated and considered merely for the purpose of giving the student body a knowledge of what those who practice medicine and surgery believe, would not be sufficient to conclude that those licensed to practice osteopathy would have the right to practice medicine and surgery."

Osteopathy In Connecticut

There are about 85 osteopaths licensed and practicing in the State of Connecticut. These practitioners are for the most part located in the larger communities and because of the small number it is quite clear that they contribute only the smallest fraction of a part of the medical care of the people of Connecticut.

These osteopaths are now seeking an extension of the privileges so that they will be allowed to administer a broad classification of drugs. Connecticut is one of the healthiest states and the quality of medi-

cal care is high. There is no shortage of physicians here. Connecticut ranks 9th among the states in proportion of physicians to population and that ratio is well above the average for the nation. No necessary or neglected function will be improved by increasing the privileges of osteopaths. The proposed bill is clearly legislation designed for the sole purpose of improving the economic status of the few practitioners of osteopathy in the State and their successors.

Shall Osteopaths Be Allowed to Practice Medicine In Connecticut Without Adequate Examination

Section 2754, Revised Statutes 1930, provides that any registered osteopath may appear before the Connecticut Medical Examining Board for examination and, if he passes, he is licensed to practice medicine or surgery or both. Several osteopaths have already qualified under this law. The question that now arises is, shall graduates of colleges of osteopathy be permitted to practice medicine in this State without having passed an examination in medicine before the Connecticut Medical Examining Board? The natural corollary to this question will be, have Connecticut osteopaths the desire to practice medicine, abandoning the fundamental principles which the founder of osteopathy so clearly enunciated during the years?

If the osteopaths have not abandoned this principle of their profession, how do they justify the addition of medicine to a theory of healing completely based upon the premise that the cause and cure of all diseases are dependent upon structural adjustments of the body without the use of medicine? If they have abandoned this fundamental principle and if they now believe in the use of medicines in the same manner and the same degree and for the same purpose as a doctor of medicine, how then do they justify the existence of their practice as a profession separate and distinct from the medical profession?

If S. B. 519 is correctly understood, it is evident that the few osteopaths in Connecticut desire to authorize some of their number now in the State to engage in the practice of medicine. Do they thereby claim that osteopaths who by their own admission were taught that medicine was injurious and unnecessary, should now have the right to use medicines on the people of this State?

If the practice of osteopathy in Connecticut is to continue as has been contemplated since early in this century, the present statutes are adequate for

the regulation of the profession. If, on the other hand, osteopathy has expanded to include the use of drugs and the practice of surgery as was suggested before the legislature of 1939, then it is the practice of medicine that osteopaths engage in and not the practice of osteopathy.

Federal Legislation

CONSTRUCTION OF COMMUNITY FACILITIES

H. R. 3570, a bill introduced by Representative Lanham, of Texas, would authorize an appropriation for additional community facilities made necessary by national defense activities. The introduction of this bill resulted from a special message sent to the Congress by the President asking that the additional appropriation be made.

A federal appropriation of \$150,000,000 is contemplated. This money will be used, in accordance with such directions and regulations and on such terms and conditions as may be prescribed or approved by the President, (a) to make loans or grants or both to public agencies for the construction, rehabilitation and operation of facilities; (b) to construct, operate, lease or sell facilities, including the acquisition of land and the demolition, repair, or alteration of existing structures where necessary; and (c) for necessary administrative expenses.

The House Committee on Public Buildings and Grounds, to which the bill was referred, held public hearings on it March 4, 5, 6, 7, 12 and 13. The Assistant Coördinator of Health, Welfare, Education, Recreation, and Related Activities, Mr. Charles P. Taft, was one of the witnesses who appeared before the Committee to urge the immediate enactment of the bill. He told the Committee that the federal money would be expended for school facilities, sewerage disposal systems, community centers, mosquito control work, milk pasteurization plants, water supplies, and for medical and hospital facilities and care. He stated that \$25,000,000 of the appropriation would be used for the construction of hospitals and \$4,200,000 for the construction of clinics. In addition, annual grants of \$2,200,000 would be made for the care of transient indigents, and \$2,800,000 for their ambulatory care. Furthermore, annual grants of \$1,000,000 would be made for hospital operation.

In a prepared statement, Mr. Taft said in part:

"From the standpoint of Medical care, especially hospitalization, the civilian population of defense

areas may be considered under two broad categories (1) The employed or self-sustaining group, who on account of improved economic conditions in defense areas should constitute a large part of the total population, perhaps 75%; (2) the dependent and medically indigent group who cannot meet the costs of major illness. About one-half of this latter group will be local residents and their care should be a local responsibility. There will remain approximately 190,000 persons who because of residence laws are excluded from such public assistance as the community affords and for these the Federal Government should make necessary provisions.

"In addition to accommodations for bed patients there should be facilities for ambulatory or out-patient care and for public health services. These facilities may be provided through the hospital or may be developed separately. Even in communities where bed accommodations are relatively well provided, out-patient and public health facilities may be very inadequate.

"Information available indicates that roughly 1,500,000 civilians will move into extra cantonment and newly developed industrial areas. To provide hospital accommodations for this group will require 6,300 new beds. The capital outlay entailed for the construction and equipment of facilities represented by this number of beds at \$4,000 per bed will be approximately \$25,000,000. In some localities, especially where no hospitals existed previously, the revenue derived from the use of facilities may not be sufficient to meet the maintenance costs. Under those circumstances annual grants from Federal sources would have to be considered to insure operation of the added facilities during the national emergency. Facilities represented by 50% of the new beds may require operating grants equivalent to 33⅓% of the annual cost or \$1,000,000 a year during the period of the emergency.

"Approximately 120 health center buildings are needed to provide suitable accommodations for health departments and out-patient clinics. The average cost of construction and necessary equipment for such units is \$35,000, thus entailing an expenditure of \$4,200,000. Communities themselves or through grants-in-aid under the provisions of other State or Federal Acts render service to transient indigents toward which a specified amount might be paid by the Federal government. For the latter item an allowance of \$14 per capita per annum, or a total of \$2,800,000 is made.

"The transient indigent group will require hospitalization equivalent to two hospital days per capita or 400,000 days of hospital care per year. For defraying the cost of hospital care alone at the rate of \$3.50 per day \$1,400,000 will be required. To this amount should be added \$650,000 for physicians' services.

"It is believed that all clinics, and that hospital facilities represented by 50% of the beds can be constructed or placed under contract during the first year. Federal responsibility for medical care for indigent transients should be started at once. Pending the construction of new facilities no doubt partial accommodations may be secured on a rental basis."

COMPENSATION FOR DRAFT EXAMINERS

S. 985, introduced by Senator Russell, Georgia, February 26.—A bill to amend the Selective Training and Service Act of 1940 so as to provide compensation for members of local boards and for other persons assisting in the work of such boards. Pending in the Senate Committee on Military Affairs.

This bill provides that members of local boards appointed under the provisions of section 10 of the Selective Training and Service Act, and physicians and other persons who render services in connection with the work of such boards and whose compensation for such services is not otherwise provided for, shall be paid at the rate of \$4 a day for time actually spent by them in conducting or assisting in the work of the boards.

CONSTRUCTION OF HOSPITALS

S. 1230, introduced by Senator Brown, Michigan, for himself and for Senator Wagner, New York, and Senator George, Georgia, March 27.—A bill to provide for the general welfare through the construction of needed hospitals and grants to States and political subdivisions thereof for the construction, improvement and enlargement of hospitals. Pending in the Senate Committee on Education and Labor.

This bill is identical with the Wagner-George hospital construction bill as passed by the Senate in the Seventy-sixth Congress. It retains the provision for osteopathic representation on the National Advisory Hospital Council to be created by the bill. It retains, too, the broad definition of the term "hospital," the word being defined to include health, diagnostic, and treatment centers.

DENTAL CARE FOR VETERANS

S. 1194, introduced by Senator Shipstead, Minnesota, March 20.—A bill to authorize the Administrator of Veterans' Affairs to furnish dental care to veterans. Pending in the Senate Committee on Finance.

By the provisions of this bill, the Administrator of Veterans' Affairs would be directed to furnish free dental care to any honorably discharged war veteran who has a service-connected disability.

THE FORUM

Two new sulfonamide compounds are undergoing clinical trial and may soon be commercially released. The first one is sulfadiazine, a close relative of sulfathiazole and sulfapyridine. Extensive preliminary tests indicate that it has a wider range of therapeutic usefulness with a considerably lower toxicity than the older drugs. Nausea and vomiting, mental confusion, jaundice, blood dyscrasias and erythemas have been notably rare and when seen extremely mild. Crystallisation in the urinary tract has not been reported.

Its therapeutic efficiency combines all the best features of the older and several of its own. Conjugation in the blood stream is slight. High concentrations are easily reached and maintained longer, yet without evidence of drug retention. This indicates that doses may be spaced at longer intervals. Diffusion throughout the body tissues is excellent. Effective high concentrations can be obtained in the spinal, pleural, synovial and peritoneal cavities.

The second compound is sulfaguanidine. This drug may well be the solution to the search for an efficient intestinal antiseptic. Early reports on its use in the infectious enteritides—ulcerative colitis, typhoid and the bacillary dysenteries—are guardedly enthusiastic. However they are too incomplete to warrant definite conclusions. In a later Forum we hope to have more information.

In connection with the use of sulfonamides in general, several of our leading clinicians and research men have expressed certain precautionary opinions. They stress the fact that these drugs are not cure-alls and deplore the diagnostic let down that has followed in the wake. Accurate diagnosis is still the goal to be achieved. Since the late and remote toxic effects on the blood forming tissues,

brain and central nervous system, liver, kidney and heart are as yet unknown, the use of these drugs should be limited to specific conditions.

We listened to a talk on vitamin B deficiency diseases given by Tom Spies, a pioneer in this research item. What he had to say was extremely interesting. One statement in particular was most arresting: that from 25% to 40% of Mr. Average American suffers from a lack of one or more of the B components. He agreed that it was a broad statement but that it could be easily confirmed by doing a simple urine test on all patients coming into the office. The test: place 3 cc. of urine in a test tube and acidulate it with 2 or 3 drops of acetic acid, then add 10 cc. of ether and shake well for 5 minutes. Allow the solutions to stratify. A color will appear in the ether fraction that varies from a light tan to a dark brick red depending on the severity of the deficiency. He then went on to describe the many disease syndromes attributed to inadequate B intake, centering his attention on the newer discoveries. Chief of these is pyridoxine (B-6). This factor is being used in the treatment of muscular weakness—myasthenia gravis and the dystrophies—epilepsy and other convulsive states, Parkinsonism and the scleroses. The vitamin is given by hypodermic in 50-100 mg. doses every day. The results have been definitely encouraging.

One other item of more than ordinary interest is the identification of an anti-gray hair fraction, p-amino benzoic acid. In experimental animals lack of this acid causes the hair to lose its natural color, but as soon as it is restored to the diet the color returns. He holds out a definite hope for graying heads.

His comments on treatment are noteworthy. Doses must be large and if results are less than expected they should be given by hypodermic, as many of these patients have faulty absorption from the intestinal tract. If difficulty with flushing is experienced in the use of nicotinic acid he recommends the use of nicotinic acid amide.

T. P. R., M.D.

OUR NEIGHBORS

New York Medical Society On the Air

The Public Relations Bureau of the Medical Society of the State of New York has inaugurated

a series of half-hour dramatized presentations, "Doctors for Defense." This program will be heard every Wednesday evening at 10 o'clock over Station WMCA, New York. This program is the result of a study of current medical broadcasts made by the Public Relations Bureau upon instructions from the 1940 House of Delegates. The study has been an exhaustive one and has led to the conclusion that such programs must be enacted, not read. For this reason scripts are not being distributed to the general public.

"Doctors for Defense" is a documentary, human interest program showing objectively the part performed by the doctor in practically every phase of American social life today. The purpose of the program is to show the doctor as an integral, indispensable factor in the activities by which Americans keep alive; activities by which Americans learn, make a living, and amuse themselves; activities by which Americans are today preparing to defend their land and their way of life.

New Jersey

Medical Service Administration

The Medical Society of New Jersey has placed in operation a non-profit plan for medical care known as the Medical Service Administration of New Jersey. Its affairs are to be administered by a Board of governors of eight members appointed by the Board of Trustees of the Medical Society of New Jersey, at least five of which shall be members in good standing of the Medical Society of New Jersey. The plan is designed as a method of enabling single persons with yearly incomes under \$1800 to obtain medical services, particularly in time of catastrophic illness. In order to function at least fifty one per cent of the members of a County Medical Society are required to sign a written agreement. On March 1 eight counties had qualified for participation leaving thirteen still unenrolled. Details of the plan appeared in a supplement to the *Journal of the Medical Society of New Jersey*, February, 1941.

THE DOCTOR'S OFFICE

D. Leonard Lieberman, M.D., of Chester announces the opening of an office, limited to the practice of allergy, in the Central National Bank Building, Middletown.

NEWS

from County Associations

Fairfield

The 149th Annual Meeting of the Fairfield County Medical Association was held on Tuesday, April 8. The following officers were elected:

President, Ralph Crane, Stamford.
Vice-President, Charles Sprague, Bridgeport.
Secretary, J. Grady Booe, Bridgeport.
Treasurer, Clifton C. Taylor, Bridgeport.
Councilor, Samuel F. Mullins, Danbury.

New members elected to the board of trustees were Don J. Knowlton, Greenwich and Clifford D. Moore, Newtown. Following an excellent dinner the association was addressed by Doctor John F. Fulton, Professor of Physiology at Yale University, and a member of the National Research Council. Doctor Fulton outlined the history of the National Research Council and developed its significance in the present crisis. He then discussed "War Medicine in Great Britain" from observations made during his visit to England last fall in behalf of the National Research Council. Of particular interest were his remarks on physiology of concussion, the treatment of wounds by complete closure and immobilization in casts, and the use of sulfonamide drugs in infected wounds.

The Stamford Medical Society was addressed on April 15 by Doctor Gray Twombly of Memorial Hospital, New York, on "Relationships between Hormones and Cancer."

The Bridgeport Medical Association had an unusually interesting meeting on April 1 when Doctor Joseph E. J. King, attending surgeon Neurological Service of Bellevue, Lenox Hill and other New York hospitals told of his "Experiences with and Management of Brain Abscess."

Doctor Frank J. Aldwin of Stamford is at Camp Blanding, Florida, on active duty with the 142nd Field Artillery of the Connecticut National Guard. Doctor Ralph E. Costanzo, a captain in the Army Reserve, reported for duty at Fort Wright on April 15.

Hartford

Doctor James R. Miller, Chairman of the Council, addressed the Connecticut Pharmaceutical Associa-

tion in Hartford January 29 on "Social Trends which affect the Pharmacist and the Physician." Doctor Miller's paper was presented in the interest of closer coöperation between the State Medical Society and the State Pharmaceutical Association as outlined by the Joint Conference Committee.

The New York State Journal of Medicine, March 1, 1941, publishes in full a paper by Doctor Miller entitled "Early Signs of Serious Gynecologic Lesions" which was presented at the annual meeting of that Society in May 1940. Doctor Miller has been invited to present a similar paper before the Medical Society of Virginia at its annual meeting in October at Virginia Beach.

In the Proceedings of the Thirty-Fourth Annual Convention of The Association of Life Insurance Presidents appears an address by Doctor Donald B. Cragin of Hartford on Medical Preparedness.

Doctor James H. Biram, a practicing Hartford physician for 30 years and associate visiting surgeon at Hartford Hospital, has accepted the appointment of director of medicine and surgery at Colt's Patent Fire Arms Manufacturing Company, effective February 1. The increasing number of employees at Colt's made necessary the creation of the new position of medical director. About 5,000 persons are now employed at the company's three plants. In his new capacity, Doctor Biram, who has been consulting physician to Colt's for 24 years, will have charge of the medical staff at all three plants. Most of the work is surgical.

Doctor Biram, whose office was at 179 Allyn Street, was graduated from Amherst College and Cornell Medical School and was appointed consulting physician at Colt's shortly before this country's entry into the first World War, a position he retained until the present time.

Doctor Allen O. Whipple, an outstanding authority on conditions of the biliary tract including the spleen, addressed the Hartford Medical Society on Monday, April 7, concerning some of the newer aspects of conditions and diseases of this tract based on considerable research work. In the afternoon at 5:00 o'clock, Doctor Whipple gave a clinic at St. Francis Hospital at which atypical cases respectively of Thrombocytopenic Purpura and Hyperinsulinism were shown and discussed. Despite their being atypical, the results of splenectomy in the first case and partial pancreatectomy in the second were quite successful with nine years elapsing since the sple-

nectomy and almost two years since the pancreatectomy.

On or approximately May 20, 1941, the Annual Reunion of the Interné Alumni Association of St. Francis Hospital will be held.

The Hartford Hospital is in the throes of its new building campaign and with the temporary structures, matters are proceeding apace with but very little inconvenience to patients and doctors. Ground is already being broken for the maternity wing of the new hospital.

The Hartford County Medical Association held its 149th annual meeting in Hartford on April 1. Thacher W. Worthen, Hartford, was elected president; William F. Flanagan, New Britain, vice-president; Frank T. Oberg, Hartford, secretary-treasurer; Arthur B. Landry, Hartford, councilor. Several new members were elected. Doctor William Dameshek, assistant professor of medicine at Tufts College Medical School, was the guest speaker. He presented the subject, "Newer Aspects in the Blood Dyscrasias."

Litchfield

The State of Connecticut is observing the month of April as Cancer Control month. In keeping with this policy, Mayor William A. Patten of Torrington issued a proclamation urging all citizens to attend meetings of the Women's Field Army, read its literature and whenever possible, enlist in its ranks. In connection with this movement, the drive has been carried out in Torrington and adjacent towns for members in the Field Army of the American Society for the Control of Cancer. The Vice-Chairman in charge of this drive is Mrs. Martin D. Fitzgerald, 34 Barber St., Torrington; among the Chairmen for the various towns in this area are:

Mrs. Carlton H. Talcott, Wolcott Ave., Litchfield.

Mrs. Walter French, 181 High St., Thomaston.

Mrs. Raymond Brown, Harwinton.

Mrs. C. M. Keefer, Morris.

The district Medical Advisor is Doctor Francis A. Sutherland of Torrington.

Doctor Edward H. Wray, Jr. Lieut. Sr. Grade, M.C.V. (S) U.S.N.R. has been ordered to the Brooklyn Navy Yard for active duty on May 5. Doctor Wray, a member of the Associate Staff of the Charlotte Hungerford Hospital, has been prac-

ting in Litchfield for the past four years. He was graduated from the Yale School of Medicine in the Class of 1932.

Capt. William C. Kennedy of the Medical Detachment of the 102nd Infantry and member of the Associate Staff of the Charlotte Hungerford Hospital who has been stationed at Camp Blanding has been ordered to the Medical Field School at Carlisle Barracks, Penn.

Doctor Thomas J. Danaher has been appointed by Brig. Gen. Reginald B. De Lacour, Adjutant General of the State of Connecticut, as Post Surgeon in the Connecticut State Guard.

On April 10, the Tumor Committee of the State of Connecticut met at the Charlotte Hungerford Hospital. The following papers were presented:

1. Carcinoma of the Mouth—Emerson S. Hill, Torrington.
2. Carcinoma of the Cervix—Floyd A. Weed, Torrington.
3. Early Carcinoma of the Cervix—Paul Younge, Boston.

The discussion on these papers was opened by Doctor George Smith of Boston. Doctors Younge and Smith are members of the faculty of the Harvard Medical School.

There followed an animated and thoughtful discussion of the papers. Following the meeting the group was entertained at supper by the Charlotte Hungerford Hospital. This meeting is in keeping with the general plan to make April, Cancer Month in the State to which reference is made above.

The meeting of the Tumor Conference of the Staff of the Charlotte Hungerford Hospital was held on April 2. The speaker was Doctor Douglas Roberts of Hartford who gave a very entertaining and instructive lecture on "Malignant Lesions of Bone." Doctor Roberts illustrated his paper with lantern slides of roetengrams.

At the last meeting of the Journal Club of the Charlotte Hungerford Hospital which was held on May 1 in the Staff Conference Room, the following colored motion picture films were shown:

1. Vaginal Hysterectomy (Louis E. Phaneuf, M.D., Boston).
2. Transverse Cervical Cesarian Section (Louis E. Phaneuf, M.D., Boston).

Doctor Maude Taylor Griswold recently addressed the Ladies Aid Society of the Harwinton

Congregational Church. This meeting was held in the home of Mrs. Ivins Nott. Doctor Griswold discussed the effort which is now being made in Connecticut to legalize Birth Control.

New Haven

Doctor Clifford Kuh, Chairman of the Committee on Industrial Health, has recently been appointed one of a board of seven contributing editors to the "Proceedings of the Life Extension Examiners." This publication appears bi-monthly from Life Extension Examiners, New York City. On April 5 Doctor Kuh spoke one "The Relation of the Physical Environment in Industry to the Mental Health of the Worker" at a meeting of the Connecticut Vocational Guidance Association at the Choate School. Doctor George K. Pratt, Medical Director of the Connecticut Society for Mental Hygiene addressed the same conference meeting on "The Human Factor in Industry." On April 29 Doctor Kuh addressed a joint meeting of the District Nurse Association and the Chamber of Commerce of Middletown on medical and nursing service for smaller industries.

New London

The annual meeting of the New London County Medical Association was held at the Seaside, Waterford, April 3. The business meeting convened at 4:30 P. M., the dinner at 6:30 P. M., and the speaker was heard at 8:30 P. M. The following officers were elected: President, Hugh F. Lena, New London; Vice-President, Robert Glen Urquhart, Norwich; Secretary, Thomas Soltz, New London; Treasurer, Solam Segel, Norwich; Councilor, George H. Gildersleeve, Norwich; Censors, David Sussler, Norwich, 1 year; Edmund L. Douglass, Groton, 2 years; Clarence Thompson, Norwich, 3 years; the President and Secretary; Board of Trustees, E. A. Henkle, New London, 3 years; Julian Ely, Lyme, 3 years; Robert R. Agnew, Norwich, 2 years; Charles G. Barnum, Groton, 2 years; Hugh B. Campbell, Norwich, 1 year, Chairman, and John F. O'Brien, Waterford, 1 year.

Doctor Arthur Landry, President of the State Society, and Doctor J. R. Miller, Chairman of the Council, both of Hartford, were guests.

Doctor Landry spoke interestingly of his experiences in visiting the other county meetings during

his tenure of office and also of the excellent work that is being accomplished by the State Society. Doctor Miller spoke of the fine work being done by the Council. Doctor George Gildersleeve gave his annual report as the Councilor for the New London County. Reports of committees and other routine business were disposed of. The speaker of the evening, Doctor George F. Cahill of New York, Professor of Urology at Columbia, P. & S., gave a most interesting talk on "Urinary Infections." Doctor C. Y. Bidgood of Hartford, opened the discussion. A long question period followed after which the meeting was adjourned.

The monthly scientific meeting of the New London City Medical Society was held March 20, at 9:00 P. M. at the Crocker House, New London. A large attendance was present. An interesting case of a liver abscess, complicating echinococcic cysts of the liver, gallbladder and common duct was presented by Doctor Thomas Soltz. The patient, a middle aged Albanian-Greek, served in the World War at the Greek front. He evidently picked up the parasites in Albania. He had been in this country more than twenty years. His acute illness came on shortly after his parole from Wethersfield State Prison, where he had spent two years for attempted murder. The abscess was on the dome of the liver and simulated disease of the lower right lung. Consequently it was an interesting diagnostic problem. Doctor C. John Satti supplemented Doctor Soltz's discussion by presenting the case of a young married Greek woman who on laparotomy was found to have echinococcic cysts of the female adnexa and broad ligaments. About two years after this operation she developed symptoms of echinococcic disease of the liver. It was thought that the pelvic condition was metastatic from a foci in the liver and that the foci in the liver remained latent while the pelvic condition, being more active, gave rise to symptoms necessitating the exploratory operation. Both cases were from the respective services of Doctors Soltz and Satti at the Home Memorial Hospital, New London. A lively discussion followed the presentation of these cases.

News from Yale University School of Medicine

Doctor John R. Paul, Associate Professor of Preventive Medicine, delivered one of a series of six lectures on Poliomyelitis at Vanderbilt University on April 15. The lecture series was given under the auspices of the National Foundation for Infantile Paralysis.

Doctor John Leonard, Instructor in Medicine, will leave the Yale School of Medicine on June 1 to take up new duties with the Rural Hospitals Division of the Commonwealth Foundation.

Insured British Workers Found to Have Many Physical Defects

The claims that compulsory health insurance in this country will result in a healthier population appear to be refuted by the large number of physical defects found in an examination of a group of English working people who are under national health insurance. An opportunity to compare the health of a sample of British workers as to physical condition and morbidity [illness] with the numerous reports of similar investigations in the United States is afforded by an article which appears in a recent issue of the *Lancet*. The report covers an examination of 1,592 workers, including 1,352 men and 240 women. There was nothing amateurish or superficial about the examination.

Bowling

Plans are on foot to have a bowling tournament during the next meeting of the American Medical Association. It is hoped that teams can be formed representing various States. Physicians who are interested in bowling should contact Doctor Lewis W. Bremerman, 1709 West 8th Street, Los Angeles, California.

BLOOD PRESSURE? PRESTO! — You are always asking, "What's new?" The Taylor Instrument Co. answers with the introduction of a manometer cuff based on an entirely new time saving principle. Fits instantly all sizes of arms without twisting or slipping. For sale by The Professional Equipment Company. Telephone New Haven 7-2138. In Bridgeport or Hartford, Enterprise 2530.

ANNUAL REPORTS

OF THE CONNECTICUT STATE MEDICAL SOCIETY

1940 - 1941

REPORT OF THE TREASURER

The House of Delegates:

Gentlemen:

The report of the Treasurer of the Connecticut State Medical Society, for the calendar year 1940, is herewith submitted.

The many and varied details in an organization having so many activities have been most capably cared for by the Secretarial Staff in the State Office.

The Society has been fortunate, through the year, in having the counsel, advice and supervision in its financial affairs, of Seward and Monde, Certified Public Accountants. Certain recommendations made by them have been in force now for over a year and other of their suggested procedures are being adopted from time to time in an endeavor to simplify and improve the activities of this Department.

No changes have been made in the invested funds of the Gurdon W. Russell Account and the O. C. Smith Trust Fund during the year.

As the anticipated membership income of the Society may be reduced to a small degree because of exemption from payment of dues of members having been called to active military duty on and after January 1, 1941, it may be advisable to set up a reserve account of \$100 a month to take care of this contingency. When the accounts are closed on December 31, 1941, an adjustment may then be made, based upon the actual facts as they appear at that time.

The Society's financial position is sound. The membership will be interested to know that with fine coöperation from the County Secretaries the dues in arrears which on December 31, 1940 were \$4,132.50, were reduced by March 15, 1941 to less than \$300.00.

Respectfully submitted,
Hugh B. Campbell.

Seward and Monde
Certified Public Accountants
New Haven, Conn.

February 19, 1941.

Doctor Hugh B. Campbell, Treasurer,
The Connecticut State Medical Society,
New Haven, Connecticut.

Dear Sir:

We have examined the balance sheet of The Connecticut State Medical Society as at December 31, 1940, and we have made a general review of the operating and income accounts for the year then ended. In connection therewith we have examined or tested accounting records of the society and

other supporting evidence without making a detailed audit of the transactions.

Current Funds:

Cash in banks was reconciled and confirmed by direct correspondence with the depositories. Cash of \$15,773.50 is accounted for as follows:

Commercial accounts:

The Union and New Haven Trust Company.....	\$ 4,689.56
The Capital National Bank and Trust Co.	5,281.80
The Capital National Bank and Trust Co., Jour- nals revolving account	2,000.00
The Second National Bank of New Haven, Exe- cutive secretary's revolving account.....	2,004.00

Saving account:

The Capital National Bank and Trust Co.	1,795.23
Petty cash, Journal office.....	2.91

Total\$15,773.50

Accounts receivable members represents the unpaid membership dues from the following counties:

Fairfield	\$ 975.00
Hartford	1,020.00
Litchfield	112.50
Middlesex	165.00
New Haven	1,380.00
New London	450.00
Tolland .....	.....
Windham	30.00

Total\$ 4,132.50

We were informed that an extension to March 1, 1941 has been granted for the payment of 1940 dues; therefore, none of the delinquent accounts have been written off.

Accounts receivable due from advertisers in the Medical Journal amount to \$634.51. No provision has been established for accounts doubtful of collection.

Under the policy adopted during the past year, commissions have been advanced to the journal advertising agent on 1941 advertising in the amount of \$300.00.

Accounts payable of \$667.78 represents expenses applicable to the December issue of the Journal.

Accrued commissions on 1940 dues of \$206.99 represents the balance due the county secretaries for the collection of unpaid 1940 dues at December 31, 1940.

Gurdon W. Russell Fund:

Cash of \$1,647.37 in the Mechanics Savings Bank of Hartford was reconciled and confirmed by direct correspondence with the depository.

There were no changes in the following securities held by this fund during the year:

Par Value	Value December 31, 1940 Per Books	Market
\$5,000 Connecticut Railway & Lighting Company 4½% first refunding mortgage bonds, due January 1, 1951, stamped	\$ 5,350.00	\$ 5,456.25
\$2,000 Consolidated Railway Company (N. H.) 4% debenture bonds, due July 1, 1954 Cash coupon paid (50% of January 1, 1936)	230.00	325.00
\$1,000 Boston & Albany Railroad Company, 4¼% improvement bond, due August 1, 1978	820.00	655.00
Totals	\$ 6,400.00	\$ 6,436.25

We did not make a physical inspection of the securities.

O. C. Smith Trust Fund:

The principal and income cash in the Mechanics Savings Bank of Hartford was reconciled and confirmed by direct correspondence with the depositories.

Clinical Congress:

Cash in the commercial account and in the savings account was reconciled and confirmed by direct correspondence with the depositories and consists of the following:

New Haven Bank N. B. A.—checking account.....	\$ 926.34
New Haven Savings Bank	3,195.85
Total	\$ 4,122.19

Preparedness Fund:

Cash in The Union and New Haven Trust Company was confirmed by the bank.

Attached hereto are the following statements:
Balance Sheet, December 31, 1940.
Statement of Current Funds Surplus, December 31, 1940.
Statement of General Income and Expenses.
Statement of Executive Secretary Expenses.
Statement of Journal Income and Expenses and
Statement of Commercial Exhibit and Annual Meeting Income and Expenses, Year ended December 31, 1940.
Statement of Special Funds, and
Statement of Clinical Congress Income and Expenses, Year ended December 31, 1940.

Very truly yours,
Seward & Monde.

The Connecticut State Medical Society
Statement of Current Funds Surplus
Year Ended December 31, 1940

	Total	General	Executive Secretary	Journal	Commercial Exhibit and Annual Meeting
Balance, January 1, 1940	\$12,826.22	\$ 7,348.29	\$ 192.03	\$ 3,360.18	\$ 1,925.72
Add—1939 adjustments:					
Dues collected in 1940	108.00	108.00			
Advertising income	454.06			454.06	
Expense refund	60.50				60.50
	13,448.78	7,456.29	192.03	3,814.24	1,986.22
Deduct—1939 adjustments:					
Professional fees	341.82	341.82			
Dues refund	12.60	12.60			
Dues written off	11.40	11.40			
Expense paid in 1940	653.13			653.13	
Adjusted balance, January 1, 1940	\$12,429.83	\$ 7,090.47	\$ 192.03	\$ 3,161.11	\$ 1,986.22
Summary 1940 transactions:					
Income	\$39,009.58	\$24,952.12		\$10,597.45	\$ 3,460.01
Expenses	32,573.87	2,274.65	\$12,982.94	13,995.08	3,321.20
Excess of income over expenses	6,435.71	22,677.47	12,982.94	3,397.63	138.81
Allotment transfers	—	18,255.00	13,455.00	4,800.00	—
Surplus	\$ 6,435.71	\$ 4,422.47	\$ 472.06	\$ 1,402.37	\$ 138.81
Balance, December 31, 1940	\$18,865.54	\$11,512.94	\$ 664.09	\$ 4,563.48	\$ 2,125.03

Balance Sheet, December 31, 1940

ASSETS			LIABILITIES		
CURRENT FUNDS					
Cash	\$15,773.50		Accounts payable—journal	\$ 667.78	
Accounts receivable:			Accrued commissions—1940 dues	206.99	
Members—1940 dues	\$ 4,132.50		Deferred—1941 income:		
Journal advertising	634.51	4,767.01	Journal advertising	\$ 190.00	
			Annual meeting	1,037.00	1,227.00
Inventory—auto emblems ..	44.00		Surplus:		
Deferred—1941 expenses:			General	11,512.94	
Annual meeting	22.80		Executive secretary	664.09	
Legislative committee	60.00		Journal	4,563.48	
Journal advertising			Commercial Exhibit and		
commission	300.00	382.80	Annual Meeting	2,125.03	18,865.54
Total		\$20,967.31	Total		\$20,967.31
SPECIAL FUNDS					
Gurdon W. Russell Fund:			Gurdon W. Russell Fund—capital	\$ 8,047.37	
Cash	\$ 1,647.37				
Securities	6,400.00	\$ 8,047.37			
O. C. Smith Trust Fund:			O. C. Smith Fund—capital	1,492.53	
Principal—cash	1,000.00				
Income—cash	492.53	1,492.53	Clinical Congress—capital	4,122.19	
Clinical Congress:			Preparedness Fund—capital	600.00	
Cash		4,122.19			
Preparedness Fund:					
Cash		600.00			
Total		\$14,262.09	Total		\$14,262.09
Grand total		\$35,229.40	Grand total		\$35,229.40

Statement of General Income and Expenses
Year Ended December 31, 1940

<i>Income:</i>		
Dues earned	\$26,107.50	
Less, Commissions paid	1,305.38	\$24,802.12
Fee for outside services....	150.00	\$24,952.12
<i>Expenses:</i>		
Council	71.78	
Chairman of council	300.00	
Delegates A.M.A. convention	84.40	
Executive Secretary annuity	999.94	
Legislative committee	94.90	
Professional fees	350.00	
Miscellaneous	373.63	2,274.65
Excess of income over expenses		\$22,677.47

Statement of Executive Secretary Expenses
Year Ended December 31, 1940

Secretary salary	\$ 8,375.00
Office salaries	\$ 2,826.75
Less, Receipts for outside service rendered	354.31
Rent	1,020.00
Light	26.78
Telephone	174.03
Printing and postage	284.73
Office supplies and expense	282.47
Travel	150.80
Janitor	105.35
Miscellaneous	91.34
Total	\$12,982.94

**Statement of Special Funds
Year Ended December 31, 1940**

	Total	Gurdon W. Russell Fund	O. C. Smith Trust Fund	Clinical Congress	Preparedness Fund
Balance, January 1, 1940	\$13,090.89	\$ 7,729.78	\$ 1,464.84	\$ 3,896.27	—
Add:					
Interest on savings accounts	72.53	44.84	27.69		
Interest on bonds	288.75	288.75			
Excess of income over expenses	225.92			225.92	
Donation for meeting additional clerical ex- pense on special defense work	600.00				\$ 600.00
	<u>\$14,278.09</u>	<u>\$ 8,063.37</u>	<u>\$ 1,492.53</u>	<u>\$ 4,122.19</u>	<u>\$ 600.00</u>
Deduct:					
Purchase of chair and mat for New Haven office	16.00	16.00			
Balance, December 31, 1940	\$14,262.09	\$ 8,047.37	\$ 1,492.53	\$ 4,122.19	\$ 600.00

**Statement of Journal Income and Expenses
Year Ended December 31, 1940**

Income:

Advertising, net of \$1,443.00 commis- sion	\$ 9,232.10	
Subscriptions	92.00	
Reprints	1,110.09	
Electrotype	139.26	
Single copy	24.00	\$10,597.45

Expenses:

Printing and paper	8,088.39	
Postage and handling	667.90	
Stationery and supplies	100.60	
Telephone	58.30	
Secretary and editor salary	2,100.00	
Office salary	1,200.00	
Rent	240.00	
Electrotypes	439.25	
Reprints	978.06	
Editorial board expense	63.48	
Miscellaneous	59.10	13,995.08

Excess of expenses over income \$ 3,397.63

**Statement of Commercial Exhibit and Annual Meeting
Income and Expenses**

Year Ended December 31, 1940

	Total	Commercial Exhibit and Annual Meeting	Mid Winter Dinner
<i>Income:</i>			
Exhibitors	\$ 2,420.00	\$ 2,420.00	
Fees	1,014.00	400.00	\$ 614.00
Interest on saving bank account	26.01	26.01	
Total income	<u>\$ 3,460.01</u>	<u>\$ 2,846.01</u>	<u>\$ 614.00</u>

Expenses:

Directors fees	\$ 400.00	\$ 400.00	
Rent of ballroom	200.00	200.00	
Decorations and fixtures..	261.18	261.18	
Public address system, etc.	157.70	157.70	
Printing and postage	600.09	530.09	\$ 70.00
Clerical expenses	113.15	108.15	5.00
Telephone	31.62	31.62	
Speakers expenses	187.07	187.07	
House of delegates luncheons	105.89	105.89	
Luncheons and dinners...	1,151.80	456.30	695.50
Miscellaneous	112.70	112.70	
Total expenses	<u>\$ 3,321.20</u>	<u>\$ 2,550.70</u>	<u>\$ 770.50</u>

Excess of income over
expenses \$ 138.81 \$ 295.31 \$ 156.50

**Statement of Clinical Congress Income and Expenses
Year Ended December 31, 1940**

Income:

Registration fees	\$1,262.00	
Fees for special courses	108.00	
Sale of lecture prints	149.35	
Luncheon fees, etc.	408.00	
Interest on savings account	63.11	\$ 1,990.46

Expenses:

Printing and postage	572.90	
Clerical expense	132.80	
Speakers expense	226.15	
Dinners—committee	96.20	
Telephone	14.60	
Amplifying system and motion pic- ture service, etc.	67.33	
Student service	59.76	
Buttons	31.18	
Dinner expense	362.75	
Mimeograph of lectures	176.00	
Miscellaneous	24.87	1,764.54

Excess of income over expenses \$ 225.92

REPORT OF AUDITORS

Mr. President and Members of The House of Delegates:

We reviewed the report of Seward & Monde, Certified Public Accountants, as of December 31, 1940.

We made a physical inspection of the securities and savings bank books comprising the assets of the Gurdon W. Russell and the O. C. Smith Trust Funds.

Chas. T. Lamoure,
Charles H. Turkington.

REPORT OF THE COMMITTEE TO STUDY PREPAID MEDICAL SERVICE

This committee was authorized by the House of Delegates at its annual meeting in 1939, to study the subject of prepaid medical service. A progress report was made at the annual meeting of 1940.

The committee is composed of:

Chairman, Doctor Samuel C. Harvey, New Haven.

Doctor Daniel P. Griffin, Bridgeport.

Doctor James R. Miller, Hartford.

Doctor Thomas P. Murdock, Meriden.

Doctor Oliver L. Stringfield, Stamford.

Doctor Creighton Barker, Secretary, Conn. State Medical Society.

The committee has met by itself and on different occasions with executives of industry, with persons familiar with the attitude of employees, with representatives of insurance and with the insurance commissioner of the state, with trustees of the Connecticut Hospital Association, and with representatives of the county medical societies. From opinions and information so obtained, from the study of many other plans proposed and in operation and from discussion with other individuals informed in this field, the committee has prepared and wishes to present the following report.

The Problem:

The problem of providing medical care is exceedingly complicated and cannot be fully solved by any plan, simple or intricate. It is moreover not a static problem but a shift-one, changing from year to year. For many of its aspects there are no reliable data, so that any approach must be made with caution and by experiment, rather than by laying down a comprehensive plan. As experience is gained and facts obtained, a sound improvement may be accomplished by further intelligent organization, and such progress is inevitable, whether with or without the advice and action of the medical profession. It is important however that physicians take the lead in such changes rather than that they be reluctantly dragged along with them.

This committee has not been at first hand concerned with many of the basic determining factors involved in medical care, although it has not been unaware of them, for no intelligent consideration of any plan can be undertaken without such consideration. A cursory discussion of the factors providing a background for a study of prepaid medical service is necessary.

The question is often asked, "Why the necessity of any

change in the present methods of provision of medical care?" An historical generalization might be that no generation of physicians has been free from changing methods of practice. This is true not only because of the changes within medicine itself, but also because of the constantly changing environment. Specially in the last twenty years demands for change have been particularly articulate because of an increasing awareness, sometimes exaggerated, of the potentialities of medicine of today, and because of a more integrated and constrictive organization of society, leading to an inability or at least a feeling of inability to make the most of such advances in medicine.

The advancing effectiveness of medicine needs no illustration, but the accompanying economic factors do. In the first place, the costs, which frequently continue long in memory after the results have been forgotten, have increased tremendously. Even in the office and the home, modern diagnosis and treatment is no longer obtainable within the capacity of a handbag. Where the illness is of a more serious nature, hospitalization is a necessity and all of us are well aware of this increasing cost, fully justified but nevertheless placing an almost impossible burden upon most of those required to submit to it. Further, the proper development of specialization with its necessarily increased training, involving actual expenditure of monies and an equally expensive delay in the entrance into practice, has added another burden of expense for the patient. All of this it must be reiterated is proper, indeed necessary, for the adequate care of the sick individual, but imposes upon him an economic burden which is always weighty and sometimes almost, if not quite, worse than the disease.

It may be true in theory that many if not most of the population, by foresight and thrift, could anticipate such emergencies by laying aside a reserve for a rainy day. In fact, this is impossible with the large mass of the people unless a standard of living is established far below that essential to maintain good health, so that in an effort to be prepared for the contingency of illness, it may actually be precipitated. Pragmatically speaking, it is futile to cogitate about what might or should be, for we are dealing with a present circumstance, and that is the fact that the majority of the families even in this state where the per capita wealth is relatively high, are living on a yearly income below that considered adequate for a proper standard of living and are without significant financial reserves. These facts affect not only the magnitude and character of the problem involved in such a study as this, but condition materially the approach to a solution of part or all of it. It is well then to keep in mind throughout this discussion the population income distribution, by means of the following figures which are only approximately accurate, but sufficiently so for these purposes.

In a study of consumer incomes published by the National Resources Committee in 1938 (made in 1935-36), 29,400,300 families, comprising nearly 91% of the total body of consumers, received an income of approximately \$47,679,238,000. Of these 14% received less than \$500 during the year studied; 42% less than \$1,000; 65% less than \$1,500; and 87% less than \$2,500 per year. Above this level there were 10% with incomes up to \$5,000, 2% between this and \$10,000 and 1% with incomes of \$10,000 or more. While the total income is somewhat higher in the New England States and at the

present time perhaps nearly double that of the time this study was made, the relative distribution has probably not materially changed. In the individual instance moreover the income per person does not tell the whole story for it must be balanced against responsibilities involving expenditure. It is apparent that a family of two with no dependents is in a far more favorable position than one of five with three dependent children. The variables in this respect are innumerable and therefore the arbitrary use of income as a factor for classification is in itself inadequate.

So far we have been considering the ability of the "consumer" to pay, but it is equally important to discuss the physician as a "producer" in the sense of providing a service and the costs of this to the "consumer." In doing this, economic terms are used but without losing sight of the intangible things, so important in the practice of medicine. It is necessary to keep in mind that when an institution or other organization provides the "consumer" with service or materials free of charge or at reduced cost, some one pays though it is not the patient. Likewise, when the physician so acts, some one pays though it is usually he himself and the cost may be that involved in his education and the gaining of experience, which does not appear in his current accounts. Then too with the organization of medical practice, there enters the middleman, or "distributor" or "entrepreneur" as one chooses to call him, whose reason for acting as an intermediary should be that of facilitating and bettering the transfer of the product of the producer, in this case the service of the physician, to the "consumer," the patient. The practice of medicine in the recent past has been to a great extent carried on without the intrusion of the entrepreneur, but it must be accepted today that where he can make an improvement in the transfer at a cost properly proportionate to the service rendered, he will become an important factor in the practice of medicine. The burden of the proof still remains however in each instance upon those who think it advisable to introduce such an intermediary.

It must be clearly appreciated that most, if not all attempts at the organization of medical practice involve the introduction of such a mechanism. Whether it be directly under the control of the physician, as in certain private group clinics, or responsible to a consumer group as in certain "coöperative organizations," or functioning under an independent body, governmental or voluntary, it is important that it show a definite advantage and that it operate at cost, that is to say, without profit to itself.

The blanket organization of medical practice as a whole involving all economic levels and types of practice obviously could only be done by government as the entrepreneur and by obligatory legislation with the costs met by taxation of one variety or another. The necessity for this would of course have to be urgent and compelling and would involve complete abdication of individual freedom of action on the part of both the consumer and the producer. It needs no argument to demonstrate the undesirability of this to both consumer and producer, except under the most pressing circumstances.

If organization is to be introduced then, it should be directed not only at the economic level where it seems most beneficial and applicable, but also in those categories

of practice where a sound application seems possible. The diversity of practice may be considered in two fashions, first, by whom it is done and, secondly, where it is done. The former involves the specialization of practice and the latter the office, the home and institutions such as the hospital.

In general, the less severe illnesses are cared for in the office and the home by the general practitioner and by certain of the specialists such as the otolaryngologists and the ophthalmologists, the pediatricians, etc. The more severe illnesses are usually cared for in the hospital by the specialist, with the surgeon, (including the operative phases of the specialties), the obstetrician and gynecologist, and the internist, performing approximately two-thirds of the work done there. It is these illnesses, requiring the various technique provided by the hospital that are catastrophic in nature, being unanticipated and serious and involving high costs incurred abruptly and over a relatively short time.

Another distinction in medical practice while not susceptible of sharp segregation is that between preventive medicine and the case of the sick. While the individual physician primarily concerned with the treatment of illness should be alert to the possibilities of prevention and active in its application, he has no method of compelling his patients to submit to preventive measures nor can he embark on effective mass education of the public in this respect. Nor will the majority of his patients willingly submit themselves to the additional costs involved in such a program. No voluntary plan of organization for providing this service has been successful, and the preventive phase of "compulsory health insurance" has fallen far short of the expectations of its promulgators. It is highly probable that the present methods of introducing and applying preventive medicine are sound in principle and merely need further development along these same lines in order to make them even more effective. At least one must face the fact squarely, that no voluntary organization of the practice of medicine will be directly and appreciably successful in the field of prevention.

With this general consideration in mind the more specific points of study of the problem of "prepayment medical care" may be taken up, under certain headings.

The Demand for Prepayment Medical Care:

The desire on the part of the consumer for medical care at a lower cost is unquestioned, but this is true of most commodities. This attitude is peculiarly conditioned, however, by the presumption that adequate medical care is a fundamental thing to which every one is entitled. Whether this is true or not is in a way beside the point, for it belongs in a group concerning which a similar assumption is made: namely, shelter, food, clothing and education. A demand or even a desire on the part of a considerable number for a prepayment plan such as is being contemplated in this committee has been difficult to ascertain. The reason for this is apparent, since the proposal is as yet a theoretical one and there are no working illustrations of it with which those queried are familiar. The attempt to elicit such a demand at the present moment, would be analogous to a similar attempt in regard to the automobile before any were in service. It is to be noted however that subscribers to the "hospital plan" not infrequently ask if there is a similar

method for taking care of the medical costs during hospitalization.

It is the opinion of the committee that while there is at the moment no overwhelming demand for this service, there would be a considerable response were a feasible plan adopted.

The Need for Prepayment Medical Service

A question of a somewhat different character relates to the need for a "prepayment medical service." With all those with whom the matter has been discussed, there has been no question as to the need for such a service in certain economic levels. Even those who were most sceptical of its practicality were willing to concede this.

Three factors are involved in determining the character and extent of this need: namely, the economic status, the severity of the illness, and the type of care required. Let one take a "normal" family of husband and wife and two or three dependents, with an income of \$1,000 per annum or less, that is to say, a maximum weekly wage of around \$20, or an hourly return of 50 cents where the wage earner is steadily employed throughout the year. For such a family an adequate though minimum standard of living would require the expenditure of at least \$2,000 per year. It is at once apparent that the great majority of such families will not and cannot set up any financial reserves by any means now available. That they will therefore be unable to pay for the costs of severe illness out of savings or out of the current budget seems certain, for the majority of such illness will require hospitalization and medical care of a specialized nature. A small portion of this group who are steadily employed may undertake the "hospital plan" but the majority when care is necessary will become "ward patients," the cost being borne for the most part by public or philanthropic funds. A still smaller group, probably inconsequential numerically, would subscribe to a "prepayment medical service plan," were the payments of the same magnitude as those made for the "hospital plan." The less serious illnesses usually cared for in the home and the physician's office, for the most part by the "general practitioner" as contrasted with the specialist, would throw a more constant and predictable as well as a less costly burden upon the wage earner. Nevertheless, this is a burden which the majority in this group could meet only with great difficulty or not at all. Certainly, no voluntary assumption of costs, no matter how distributed, and whether for prevention or for cure of illness of any category, can be expected to meet the needs of those in this economic level. This problem should be seriously considered by the medical profession, but it is not within the province of this committee to do so, once it is acknowledged that a voluntary prepayment medical service is not feasible.

Let the same family with an income of between \$1,000-\$2,000 per year be considered. Again it is unlikely in the great majority of instances that any substantial reserves will be made available for the cost of illness. The hospital plan, although necessarily restricted in its application because of the necessity of financial soundness, offers an opportunity for protection against the "hospital costs" which should be and is being taken advantage of by a great number of persons steadily employed in industry. This of course covers no portion of the costs of illness cared for in the home or

in the physician's office. There is in this category an opportunity, the amplitude of which only experience can ascertain, to establish a "prepayment medical service plan" to cover the costs of hospitalized illness, provided it can be sold in sufficient quantity and with a sound distribution. Insofar as domiciliary and ambulatory care are concerned, the problem is a much more difficult one. Illness involving hospitalization, a greater part of which involves operative procedures, carries with it a penalty, automatically guarding against any considerable abuse. This fulfills one of the essentials of any insurance or prepayment arrangement. The contrary is the case in ambulatory or domiciliary care. In the first instance also the episode is unusual and catastrophic, involving major expenditures; in the second, the service is frequent and relatively inexpensive, thus falling readily into a budgetary arrangement, rather than into a prepayment or insurance plan. There has not yet been evolved a satisfactory voluntary prepayment plan for the coverage of domiciliary and ambulatory medical care, although many have been suggested. It is in this particular field that so-called "group insurance" proposes to give a better quality of care at a lower cost, an admirable thing in the abstract, but in practice on a voluntary basis, its feasibility still remains to be proved. The "group practice" so far as it has been successful has been based as a rule upon either a blanket compulsion, as in industrial concerns, or has dealt with higher economic levels than those which we are now considering.

Let us take again the test family but this time with an income of \$2,000 to \$3,000 per year. It is apparent that an adequate financial reserve will not be set up without difficulty and without consistent saving over many years. Therefore, the catastrophic illness involving hospitalization will still be in most instances an economic disaster. Certainly the "hospital plan" is admirably adapted for this group and is well within its means. So also would be a "prepayment plan for medical care" for hospitalized patients. The laying out of a plan for ambulatory and domiciliary care is however no more practical here than it was in the preceding economic level. However, it is not so badly needed, for the expenditures in this category of medical care would not as a rule be beyond its budgetary resources.

At the economic level above \$3,000 income per year no special consideration needs to be given, for on the one hand families falling into this category are better able to care for themselves, and on the other they comprise so small a percentage of the population (less than 10%) that the weight of the problem does not fall here.

It would seem then that the "hospital plan" has a potential field of application to those with an income of \$1,000 per annum and over, comprising some 60% of the population, and that a "prepayment medical care plan" might have a potential market at the income level of \$1,500 per year and above making up some 35% of the population.

This picture roughly presented is still too optimistic, for the conditions under which both the "hospital plan" and the "prepayment medical plan" can be set up and be financially sound, will probably restrict the potential market by 50%, bringing the former down to an over all figure of around 30% and the later to 15-20%.

As the committee has discussed these many aspects of the problems, it has become increasingly clear that any prepay-

ment plan for medical care must be experimental and restricted at the first to the component of medical care where it is at the same time most needed and most subject to adequate control. With this in mind its attention has been to a considerable degree concentrated on a prepayment plan for medical care of hospitalized patients. It is thought that this is a workable experiment, partly because a similar plan has now been in operation in Michigan with apparent success for a year and the factual data of this experience would be available, and partly because a large amount of data is at hand from the experience of the "hospital plan," particularly as to the distribution of disease and the incidence of hospitalization. A sample block of patients hospitalized under the "hospital plan" has been studied in respect to the estimated cost of the medical care involved, both by estimates of qualified physicians and surgeons of our own society and by comparison with several standard fee tables applicable to similar groups of patients. As a result of this the committee feels that it would be possible and indeed desirable to set up a "prepayment plan for medical care of hospitalized patients" which would cost the subscriber approximately the same amount as does the hospital plan and would provide sufficient income for proper professional fees, for administration and for creating the necessary reserve. If this were done, it should be closely correlated with the "hospital plan" as has been done in Michigan particularly in administration, sales and collections. Complete autonomy in control and financial resources should be retained. Enough information is at hand to enable a committee to draw up such a plan in detail.

As a result of its considerations the committee wishes to make the following recommendation:

- (1) That no attempt be made at the present to introduce a plan for prepayment medical care to cover preventative medicine, or domiciliary and ambulatory medical care.
- (2) That a committee be empowered to proceed with the development in detail of a plan for prepayment medical care for hospitalized illness for subsequent consideration by the House of Delegates.

REPORT ON THE COMMITTEE ON MEDICAL PREPAREDNESS

Preliminary Organization:

Following the request of the Surgeon General of the Army, Navy and Public Health Service, made to the American Medical Association in June 1940, a National Committee on Medical Preparedness was established. Later as part of the national organization, a physician in each state was designated by the National Committee to be the State Chairman on Medical Preparedness. The Chairman in Connecticut asked the Presidents of each of the County Associations to name a representative to serve on the State Committee and from that point on our organization developed rapidly. The Chairmen designated by the County Presidents were: Fairfield, H. Bertram Lambert; Hartford, Donald B. Wells; Litchfield, Francis A. Sutherland; Middlesex, George A. Elliott; New Haven, Ralph E. McDonnell; New London, Daniel Sullivan; Tolland, Donald A. Beckwith; Windham,

Edward J. Ottenheimer. Late in the year of 1940 Doctor Elliott removed from the State and Doctor Carl C. Harvey was appointed to succeed him in Middlesex County.

Throughout the entire course of the Committee's activity it has enjoyed the close coöperation and advice of General Sanford H. Wadhams, a member of this Society, who was appointed by Governor Baldwin as the Chairman of the Joint Defense Committee of the State.

The projects of this Committee are continuing to expand and fall into several separate categories in the field of defense and preparedness.

The Selective Service:

Securing medical personnel for the operation of the Selective Service was one of the first of the Committee's functions. From the beginning of the operation of the Selective Service System, the Committee has worked in the closest relationship with the State officials and it is not to be doubted that having this Committee serve as a coöperative agency with the government has simplified the operation of the medical side of the draft. It has also made possible the clear understanding of the private physician and his relation to the operation of the draft mechanism.

Major William B. Smith, National Guard Medical Officer attached to the Selective Service Headquarters in Hartford, is a member of this Society and through his willingness to coöperate and maintain the principles and ideals of the Society the official relationships of this Committee have been pleasantly productive.

There are more than 300 members of this Society serving as medical examiners to local Selective Service Boards and on the five District Advisory Boards. They are giving unselfishly of their time and skill and the State is deeply indebted to them for this practical evidence of their patriotism.

Army Induction Board:

At the beginning of the operation of the draft Connecticut was informed that the Army Induction Board for the State, which is the final examining board that accepts and inducts recruits into the Army, would be manned by Connecticut physicians. This type of organization is somewhat unique and added to the requirements for medical personnel. The organizing of the Board and its operation has been under the local direction of Doctor Donald B. Wells, Chairman of the Medical Preparedness for Hartford County, and Doctor Wells' organization has worked smoothly and with high satisfaction. To date the Board has processed and sent to Army posts over 7000 recruits.

American Medical Association Questionnaire:

Brief mention will be made of the American Medical Association questionnaire that every physician in the country was requested to complete and return. Connecticut was charged with the responsibility of collecting about 2600 of these questionnaires and at the time of writing this report there are not more than 150 that have not been returned.

Medical Reserve Officers:

At the request of the Chief Surgeon of the First Corps Area the Committee has submitted information concerning

technical qualifications of reserve officers and it is likely that this function of the Committee will be extended.

Public Safety:

A major activity of the Committee has been an endeavor to plan reasonable procedures in medicine and health as these relate to the protection of the civilian population. It has appeared that there are two medical problems that present themselves in the preparedness program.

The first is the maintenance of public health, control of infectious diseases, the protection of water supplies and other functions that are included in public health administration. The maintenance of these public services in time of emergency should surely be left with the State and local public health authorities. The State Health Department in Connecticut under the direction of Commissioner Osborn, has its preparedness plans well outlined and this Committee has been pleased to cooperate in the development of those plans and will continue to participate in their operation.

The second phase of medicine's participation in the defense program has to do with the maintenance of the health of the civilian population and providing emergency care in the event of disaster.

In the development of its programs in this field of public safety, the Society's Committee has sought and obtained understanding cooperation from other groups and organizations that are concerned with medical care. Conferences have been had with representatives from the Connecticut Hospital Association, the Connecticut State Nursing Association, and representatives of the Connecticut chapters of the American Red Cross. Gradually the purposes and objectives of these several groups are being brought into orderly relationship.

The function of the State Police falls most clearly into the field of the protection of property and persons, but the Department of State Police in Connecticut, under the direction of Commissioner Hickey, has developed so comprehensive a plan for the protection of our citizenry that medical and hospital care quite logically were included in it. Our Committee has been in frequent conference with representatives of the Department of State Police as its plan has progressed and stands ready to assume its proper responsibility in that pattern when it is placed in operation. In the development of the State Police program particular attention has been directed toward transportation of sick and wounded persons in which medical personnel have an important role.

Many cities and towns have already formed community plans for medical care in disaster and the evacuation of injured persons. Splendid leadership in these developments has been taken by the county chairmen of the State Medical Society's Committee. As time goes on other well organized units will come into existence.

Through the efforts of your Committee, acting with the approval of General Wadhams and Commissioner Hickey, the National Red Cross has provided 1500 cots and 3000 blankets for emergency use in the State.

The Committee has worked closely with local Red Cross Chapters in the development and extension of instruction in civilian first aid and many members of this Society are

serving as instructors to such classes in industries and communities throughout the State.

Medical Care in Industry:

Connecticut has felt the greatest effect of the preparedness effort in its industries, and the resulting industrial expansion has brought new problems in medicine. These have to do with the care and protection of the worker and the maintenance of his health and the establishment of organization within the plants to render medical service under emergency conditions. Expansion in these fields has already taken place through the individual initiative of the plants and their excellent medical staffs, and is keeping pace with the new demands on our industries. The Bureau of Occupational Diseases in the State Department of Health under Doctor Albert S. Gray, has broadened its activities and supplements the work of plant physicians, chemists and safety engineers in the elimination of occupational hazards.

Nutrition:

The Society is represented on the State Committee On Nutrition by Doctor John C. Rowley and through his membership on this increasingly important State Committee the medical aspects of the great nutritional problems will have understanding consideration.

On every hand the Committee has met with the most generous and enthusiastic help from members of this Society and other organizations, and grateful acknowledgment is here made for their invaluable aid, without which the Committee could not have progressed.

No one can say what your Committee may be called upon to do in the future but it is likely that its work has only just begun. From the first it has been the Committee's policy to develop a flexible organization, using the county as the unit, that could be relied upon to meet the varying demands which must be expected from Federal, state and local authorities.

George M. Smith, Chairman.
Creighton Barker, Secretary.

Base Hospital 39, Yale School of Medicine:

At the request of the Surgeon General of the United States Army and approved by the President and the Corporation of Yale University, Base Hospital 29 has been organized at the Yale School of Medicine through the efforts of Doctors Ashley W. Oughterson and James C. Fox, Jr. The medical officers forming the staff of this organization are over fifty in number, most of whom are members of this Society.

School of Anesthesia, Hartford Hospital:

Early in the autumn the Hartford Hospital was requested by the United States Army and the National Research Council to organize a school of anesthesia under the direction of Doctor Ralph M. Tovell. This organization is now functioning in a successful manner.

The Connecticut State Medical Journal and the Preparedness Program:

The State Medical Society and the Committee on Preparedness appreciate deeply the support given to the preparedness program by Doctor Stanley B. Weld and the Editorial Board of the Connecticut State Medical Journal.

Many announcements and discussions dealing with preparedness have appeared in its pages, and the Journal has published a number of special articles concerning medical-military matters.

National Service:

Beside the above mentioned activities in our own State, many members of The Connecticut State Medical Society are serving as members of various national committees meeting in Washington. A list of those participating on national committees will be announced in a subsequent report.

George M. Smith, Chairman,

REPORT OF EDITORIAL BOARD OF THE JOURNAL FOR THE YEAR 1940-1941

To the House of Delegates:

Gentlemen:

One has but to examine a copy of the Journal of one year ago and compare it with a current number to appreciate the changes that have transpired. The most striking difference is in the cover, type and format which, except for arrangement, bears little resemblance to the Journal of 1940. As one of our friends in Indiana has said, "it is very good looking, too." Due credit belongs to each member of the Board for his part in formulating these changes which should make the Journal more readable and hence more valuable to our members. We are starting out upon a new era of publication with a different printer, improved paper and new type.

The Journal is still endeavoring to print in full or by abstract such papers as are presented at the Annual Meeting and at the Clinical Congress which afford manuscripts suitable for publication. Because of the large amount of material at hand it is becoming increasingly difficult to accomplish this within a period of twelve months. In addition leading articles have been procured by request from eminent authorities dealing with scientific, economic and social problems—all medical in nature—which have been considered of particular interest to our readers.

The departments have been increased to include a Medical Preparedness Section and a Legislative Section. A regular news column from Yale University School of Medicine has been added. A series of case reports, one each month from one of the hospitals in the State, is now a regular feature. Preparatory to the Sesquicentennial in 1942 a series of historical articles has been appearing beginning with the issue of November 1940. This first historical series dealt with characters and events in the different counties and is still in the process of publication. A second historical series began with the April 1941 number and is so set up that it can be collected and published in book form at the time of the Sesquicentennial.

Little change has occurred in the advertising section of the Journal. Although the proportion of advertising to reading matter is not as large as it should be if the Journal is to be self supporting, yet there is a slow but steady upward trend which is encouraging.

The entire Editorial Board and the staff of News Editors

have given invaluable assistance in formulating policies and in assisting the Editor in his duties. It has been necessary because of illness to replace the office secretary, Miss Clara G. Ware, who has faithfully contributed to the success of the Journal in its five years of existence. Her successor, Mrs. Marjorie Parker, has already proven her ability to fill this important position.

Respectfully submitted,
Stanley B. Weld, M.D., Editor.

REPORT OF COMMITTEE ON THE CLINICAL CONGRESS

The Sixteenth Clinical Congress of the Connecticut State Medical Society was held at New Haven on September 17, 18, and 19, 1940. Although it has become customary to say each year's Clinical Congress was better than the last, fresh praise, unconditioned by habit, has been given to the Congress of last September. Neither war nor weather interfered with attendance at the presentations of excellent papers and demonstrations by authorities in the sessions arranged by Doctor Louis H. Nahum, chairman of the Program Committee. All exercises, except a few section meetings and clinical conferences, were held in the Sterling Law Buildings, kindly placed at the service of the Congress by Yale University. It was not only a convenience to have nearly all the meetings, including luncheon, in one building, but the arrangements served also to keep the group together and in that way aided social, intellectual, and personal contacts among physicians of the State.

The number of registrations, 700, was the largest in the history of the Congress. Of these 631 were paid and 69 were free. The Congress was attended by 617 residents of Connecticut and 83 physicians from other states. Members of the Connecticut State Medical Society among the registrants numbered 481 or 68.7 per cent of the total. Year after year the Congress draws approximately two-thirds of its attendance from the State Medical Society. This proportion is only about one-third of the Society's membership. The Committee wishes that more members of the Society would attend the Congress, and has tried by notifications, publicity, and construction of programs to attract the physicians of Connecticut. In spite of successes in other directions, a degree of failure in the home territory of the Congress must be admitted. After detailed analysis of the statistics of registration, however, Doctor Maurice J. Strauss, chairman of the Committee on Publicity and Registration, comments: "If one can draw any conclusion at all, it is that the Congress has been accepted as a valuable contribution to the life and work of physicians in and around Connecticut and continues to receive their support."

Comparative registration figures for the six-year period since 1935 are as follows:

Clinical Congress	Year	Number of Registrants
11th	1935	627
12th	1936	633
13th	1937	694
14th	1938	598
15th	1939	581
16th	1940	700

The report of the Treasurer, Doctor Charles E. Sanford, is as follows:

Receipts:

From registration fees and luncheons.....	\$ 1,811.75
Interest on deposits in bank.....	63.11
Total receipts	\$ 1,874.86

Disbursements:

Printing	505.49
Clerical work	253.71
Dinners (Committee)	96.20
Luncheons	362.75
Speakers' expenses	226.15
Miscellaneous	204.64
Total disbursements	\$ 1,648.94

The surplus of receipts over disbursements amounted to \$225.92.

The total assets of the Clinical Congress, in the form of bank deposits, amounted to \$4,122.19, as of December 31, 1940.

As usual work on plans for the next Clinical Congress was started soon after the close of the last. On November 30 a dinner meeting of the program committee held at the building of the New Haven Medical Association was well attended by officers of the Society and representatives of the county medical societies. The Seventeenth Clinical Congress will be held at New Haven on September 16, 17, and 18, 1941, and the program is nearly complete.

At a meeting of the central group of the Committee on Clinical Congress on October 18, 1940, Doctor Nahum presented a plan for widening the activities of the Clinical Congress in sponsoring courses to be given during the winter months. This received hearty support of members of the committee and was approved by the Council. Two post-graduate courses, one on Diseases of Nutrition and one on Industrial Medicine, were then organized by Doctor Nahum. The schedule provides 14 sessions of one hour each for each course, on Thursday afternoons, for the period extending from January 9 to April 10, 1941. The Yale University School of Medicine is coöperating by providing facilities and rooms for the meetings. The announcement of these courses were well received.

The Committee on Arrangements, under the chairmanship of Doctor John H. Bumstead took care of a multitude of complicated details with its usual quiet efficiency.

A review of the activities of the past year increases my respect for the intelligence, loyalty, and industry of the members of this Committee. I want to take this occasion to renew my thanks to every member of our group.

Respectfully submitted,
S. Bayne-Jones, Chairman.

REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

A brochure entitled, "Conserving Man Power Through Industrial Medical Service," has been prepared by the Joint

Industrial Health Committee of the Manufacturers Association of Connecticut and the Connecticut State Medical Society. Well over a thousand copies have been printed by the Manufacturers Association and distributed to their membership and other interested groups. The contents of the brochure are also being reproduced in the *Connecticut State Medical Journal*.

This unique document describes the scope, function and organization of medical service in industry and contains an inquiry form, which, when completed by Connecticut manufacturers, will furnish valuable information concerning existing medical services. Upon request, manufacturers desiring information concerning the inauguration or expanding of a health program will be given assistance.

It is hoped that the brochure will be the first of a number of coöperative enterprises on the part of the Manufacturers Association and Medical Society, aiming to further the interests of the preparedness program. For example, the need for disseminating more information about organizing first aid training courses for employees has been recognized, and other measures for improving employee morale will undoubtedly become apparent.

The publication of the brochure represented the culmination of meetings and communications between the industrial and medical groups over a period of a year and it is a source of satisfaction that the two groups were able to meet on common ground in respect to all questions of policy and terminology. Before publication, written permission was sought from all members of the Joint Committee for sanction to affix the member's name to the report and all (about forty industrialists and physicians) gave consent without a single exception.

It has been a very active year from the standpoint of addressing meetings and publishing or encouraging the publishing of literature on industrial health in the *Connecticut State Medical Journal* and elsewhere. Without giving credit to individuals some of the chief activities of the Committee in this respect have been as follows:

Post graduate course on industrial medicine sponsored by the Committee on the Clinical Congress and the Connecticut State Medical Society: Lectures on "Medical and Health Services in Industry," "Preventive Industrial Medicine," and "Infections in Industry."

Address on Industrial Health, Rotary Club Luncheon, New Haven.

Address to Hartford Branch, New England Industrial Nurses Association; to Health Division of the Council of Social Agencies of Hartford; to Regional Staff Education Conference of Public Health Nurses at Clinton; to joint meeting of District Nurse Association and Chamber of Commerce of Middletown.

Address, Round Table Discussion, Third Annual Congress on Industrial Health, American Medical Association, Chicago.

Address, Symposium on Mental Hygiene in Industry, Connecticut Vocational Guidance Association.

Article, "Increasing Importance of Preventive Industrial Medicine, October, 1940, issue *Connecticut State Medical Journal*.

Article, "Physical Examinations in Industry," "Proceedings of the Life Extension Examiners," New York, Sept.-Oct., 1940.

Article, "Industrial Health—An Old Year Concept with a New Year Meaning," January, 1941, issue, *Connecticut Industry*.

Article, "Congress on Industrial Health," February, 1941, issue *Connecticut Industry*, and February, 1941, issue *Connecticut State Medical Journal*.

The Section on Industrial Health of the Connecticut State Medical Society which was sponsored by this Committee, appears now to be functioning on its own. An abstract of Edward Chester's talk before the Section last September on "Vocational Rehabilitation of the Disabled Connecticut Worker" was published in the March, 1941, issue of the *Connecticut State Medical Journal*.

The Committee is getting into its stride. It realizes full well the tremendous opportunities which are opening in the field of industrial medicine and it looks forward toward the chance to be of service with eagerness and optimism.

Respectfully submitted,
Clifford Kuh, M.D., Chairman.

ANNUAL REPORT OF THE PUBLIC HEALTH COMMITTEE

The Public Health Committee consists of the following members:

Joseph H. Howard, Chairman, Bridgeport.
Donald A. Bristoll, New Britain.
Howard G. Stevens, New Milford.
Jessie W. Fisher, Middletown.
Maurice J. Strauss, New Haven.
Howard W. Brayton, Hartford.
Albert C. Freeman, Norwich.
Karl T. Phillips, Putnam.
Luther K. Musselman, New Haven.
Joseph I. Linde, New Haven.
Howard S. Colwell, New Haven.
Oliver L. Stringfield, Stamford.
J. Harold Root, Waterbury.

Three meetings have been held during the year, at which time the discussion concerned chiefly maternal and child health. The reason for emphasis on these subjects is that Federal funds are allotted for these problems, and we, in Connecticut, are taking advantage of these funds to build the foundation for adequate maternal and child care so that our State may be prepared to take over and carry on this improved plan after Federal aid has been withdrawn.

The question of membership in the State Society as a requisite for qualification as a consultant in services carried out under direction of the State Department of Health as part of the Federal program was considered, since it was the opinion of the United States Children's Bureau that this was not essential. Our committee was unanimous in the opinion that these specialists should be members of the Society to qualify as consultants. In the pediatric consultant service a maximum fee of \$20.00 per case should be allowed for consultation. However, if a consultation requires

travel of either the obstetrical or pediatric consultant to the patient, a \$10.00 fee will be paid for a single consultation. When the patient goes to the consultant, the fee is to be \$5.00.

The Committee approved the following additional requirements for hospitals approved for the care of obstetrical cases.

- A. The obstetrical service shall be under the general supervision of an obstetrical staff having at least one physician who has been appointed as an obstetrical consultant.
- B. The attending staff and obstetrical consultants shall make a thorough review and analysis of the obstetric work done in the hospital, at least monthly, with particular consideration to all death (maternal, neonatal, and stillborn) and morbidities and complications.
- C. Adequate laboratory facilities for: blood counts, hemoglobin determinations, typing and cross-matching of blood; for blood chemistry; and for bacteriological examinations. It is recommended that the laboratory meet the approval of the State Department of Health.
- D. Adequate facilities for giving blood transfusions.
- E. X-ray equipment and trained personnel.
- F. An operating room in addition to the delivery rooms. The equipment of the operating room shall be adequate for the performing of major surgical operations.
- G. Ambulance service available throughout the area served by the hospital.

The following recommendations also have been approved: "It is recommended that a consultation be held with a specialist in obstetrics prior to any major obstetric operation and for treatment of serious complications of pregnancy.

"It is recommended that hospitals refer maternity cases who are hospitalized through the Obstetrical Consulting Service to the local public health nursing organization so that conditions in the home may be arranged to the best advantage for the patient when she returns from the hospital."

Requirements for hospitals approved for the care of pediatric cases (to include infants and children under sixteen years of age) was endorsed by the committee.

I. General requirements:

- A. Medical supervision. The pediatric service shall be under the supervision of a pediatric staff including at least one physician who has been appointed to the pediatric Consulting Service.
- B. The attending staff and pediatric consultants shall make a thorough review and analysis of the pediatric work done in the hospital, at least monthly, with particular consideration to causes of deaths and illnesses.
- C. Nursing care. A registered nurse shall be in attendance at all times.
- D. Cleanliness and management. The building, equipment and surroundings shall be kept clean at all times and the management and operation of the hospital shall be such as reasonably to ensure the health, comfort and safety of patients.

E. *Building space and equipment requirements:*

1. Fire protection. The buildings, equipment and precautions taken to provide for the safety of patients and employees in case of fire must meet the approval of the State Commissioner of Health.
2. Isolation facilities. Adequate facilities must be available for the isolation of children with evidence of infection. Individual isolation technique must be observed for all such cases.
3. Operating room. The equipment and supplies shall be adequate for the performing of major surgical operations.
4. Laboratory. Adequate laboratory facilities must be available for: blood counts, hemoglobin determinations, typing and cross-matching of blood; for urinalyses; for blood chemistry; for bacteriological examinations and for routine pathological examinations. It is recommended that the laboratory be approved by the State Department of Health.
5. Adequate facilities for giving blood transfusions.
6. Facilities for supplying oxygen and apparatus for its continuous administration.
7. X-ray equipment and trained personnel.
8. Accurate and complete medical records including history, physical examination, laboratory data and records of treatments.
9. Ambulance service within the territory served by the hospital.

The committee also approved of the following recommendation. "Separate unit. There shall be segregation of pediatric patients from other patients."

It is the opinion of the Committee that additional requirements are necessary for the care of premature infants, and therefore approves the following:

II. *Additional requirements for hospitals caring for premature infants:*

- A. A separate premature nursery or other facilities, providing segregation in a suitable environment for premature infants.
- B. A registered nurse, preferably one with special training for the care of premature infants, shall be in attendance at all times. No member of the nursing staff that cares for premature infants shall attend other patients who may have infections or contagious diseases.
- C. One incubator for every ten or less bassinets.
- D. Nursery equipped with means for maintaining a constant temperature of 75° to 80° and with some means of humidifying the room from 55 to 65.
- E. The hospital accepting a premature infant born outside of the hospital must provide a suitable nursery and isolation facilities on the pediatric service for its care.
- F. The hospital shall be provided with a portable incubator for use in transferring premature infants from the home to the hospital.

For better follow-up and proper supervision after dis-

charge from the hospital, it is recommended that "hospitals refer the cases hospitalized through the Pediatric Consulting Service to local public health nursing organizations so that the home may be prepared for the patients arrival and so that there may be nursing supervision of the patient at home."

Since Federal funds apply only to towns of 50,000 population or under, the question has been discussed whether cities or groups of towns might be considered as units. It is the opinion of the Committee that more emphasis be placed on a closer check of cases rather than restriction to population districts.

The question has been asked on several occasions whether or not it was proper for physicians attending Well-child conferences to recommend the dosage of cod liver oil and the use of cereals and vegetables in the child's diet. The Committee believes that he may properly recommend these measures and that he may also strap umbilical hernias, but the retraction of fore-skin and removal of ear wax should not be undertaken in the Well-child Conference.

At the annual meeting of the House of Delegates in May, 1940, the matter of revision of the present Connecticut statutes with respect to contraceptive devices was referred to the Public Health Committee. A sub-committee was appointed to study the problem and this sub-committee reported on October 16, 1940.

A resolution was presented and approved by the Committee and transmitted to the Council. The resolution is as follows: "After considerable investigation and discussion the Public Health Committee wishes to report to the Council of the Connecticut State Medical Society that in the opinion of the Committee it is inadvisable for the Society to take any action at this time on the contraceptive law. Nothing in this recommendation is to be construed as a limitation or restraint of the rights of any member of the Society as an individual."

In order to obtain a more accurate picture of neonatal deaths it has been found advisable to add to the birth certificates certain questions which would be of value. These include whether or not pituitrin was used, the month of pregnancy, the weight at birth. A supplemental form is also to be sent to all hospitals to include syphilis, analgesia and anesthesia.

The Committee voted to approve a change on the death certificate of infant—(b) cause of death: to delete tetanus and insert asphyxia, to break down into distinct items the "other diseases peculiar to the first year of life" and to insert blood diseases, atelectasis, epidemic nursery infection and erythroblastosis.

It was voted that when pediatricians are assigned to rural Well Child Conferences in towns where there are no resident physicians, they be permitted to have a young practicing physician accompany them, if he so desires, and with the understanding that the accompanying physician will not be paid for his services.

Attention has been drawn to the approval of raw milk by certain physicians. The Committee, therefore, voted that a statement be added to the Standards and Regulations for Physicians attending local Well Child Conferences . . . recommending the use of pasteurized milk, to be inserted

as point #10, and suggesting the use of raw milk boiled for five minutes only when pasteurized milk is not available.

At the last session of the legislature, a prenatal Wasserman bill was presented, but was rejected because of lack of funds. The Committee, therefore, approved the introduction of such a bill in the present legislature.

As outlined in the annual report of 1940, the state-wide evaluation of laboratories was approved by this Committee and at present this work is almost completed.

I should like to express my appreciation to the various members of the Public Health Committee for their splendid coöperation in attending the meetings so faithfully and in contributing so many valuable suggestions. The work of this Committee depends almost entirely on the material prepared and presented to it by the State Department of Health. The Committee, therefore, wishes to thank Doctor Osborn, and Doctors Clifford, O'Malley and Souther for their splendid coöperation.

Respectfully submitted,
Joseph H. Howard, M.D., Chairman.

REPORT OF COMMITTEE ON PUBLIC RELATIONS

Following its organization meeting at which objectives and policies were discussed at length, this committee divided itself into four sub-committees as follows: Press—Mario L. Palmieri of Middletown, Chairman, and Dolad M. Beckwith of Rockville; Radio—Barnett Greenhouse of New Haven, Chairman, and Harry L. F. Locke of Hartford; Speakers' Bureau—Arthur H. Jackson of Washington, Chairman, and Andrew M. McQueeney of Bridgeport; Scientific Exhibits—John G. Raymer of Norwich, Chairman, and Ralph L. Gilman of Storrs. These sub-committees have reported at meetings of the general committee which has determined policies.

Owing to the relatively recent setting up of a Committee on Public Relations a good deal of careful ground-work has been necessary in order to build a sound foundation upon which subsequent committees may eventually erect a strong pillar of our Aesculapian temple. Your committee feels that it has made merely a humble beginning but bequeaths to its successors some visions of very real benefits and accomplishments in the future. Reports of sub-committees are appended.

Respectfully submitted,
Harry L. F. Locke, Chairman.

I. Press Sub-committee:

The Press Sub-committee has attempted during the year to contribute articles for release to the press through the Secretary's office. It has plans for the future to utilize for publication abstracts of articles used over the radio by the various medical societies. In addition, members of the Public Relations Committee and other selected members have been requested to submit special medical articles for publication in newspapers which would aid in public education in health.

The State Medical Society should be cognizant of the fact that the best coöperation exists between the public press and the Executive Secretary of the Society. On many

occasions newspapers have submitted articles on medical subjects to him for approval before publication. To Doctor Barker belongs a good deal of the credit for the high regard and esteem which the press holds for the Medical Society.

Mario L. Palmieri, Chairman.

II. Radio-Sub-committee:

It is evident the medical profession of this State has not yet fully availed itself of the opportunities which the radio offers. A survey made this year reveals that Hartford, New Haven, and Waterbury are the only cities in the State which sponsor medical radio programs; and that no other city is even contemplating any radio medical activities.

Hartford has been on the air now for a number of years; New Haven for the past four years; and Waterbury only recently. The programs are well planned and well presented and give the public authentic medical information.

The Committee on Public Relations, cognizant of the potentialities of the radio in medical education and public relations, has set up a radio sub-committee in an effort to correlate the medical programs now on the air and to lay the foundation for an extended program whereby the interests of the public and the medical profession of the State might best be served through this all important medium.

Barnett Greenhouse, Chairman.

III. Speakers Bureau Sub-committee:

The Speakers' Bureau has prepared a list of physicians who are being canvassed to ask if they will serve on a panel, the members of which are to speak on various medical subjects before lay organizations when requests for such speakers come in. Those who are being asked are well qualified to speak on different aspects of medicine. It is planned that this panel will be formed and in readiness by early summer, at which time contact will be made with a list of lay organizations.

Arthur H. Jackson, Chairman.

IV. Scientific Exhibits Sub-committee:

The sub-committee on Scientific Exhibits has contacted several sources in regard to Health Exhibits and has obtained information of a general nature. The Committee as a whole having decided that its attention should be confined to more pressing problems during the present year at least, the more specific features of the subject have not been developed fully.

It is to be hoped that as the Committee develops in experience, and that when more funds are made available, Scientific Health Exhibits may be placed before the general public in such a way as to promote better understanding of health problems and to strengthen the patient-physician relationship.

Respectfully submitted,
John G. Raymer, Chairman.

SEVENTH ANNUAL REPORT OF THE TUMOR COMMITTEE

1940-41

There have been six meetings of the Tumor Committee during the current year. The main activities of this com-

mittee and its sub-committees have been as follows:

1. Affiliation with the American Society for the Control of Cancer.
2. The presentation to the State Legislature of a bill requesting an appropriation for cancer control.
3. The development of a standard history and physical examination form for physicians' offices.
4. Work on the compilation of a handbook for dentists.
5. The drive for annual physical examinations.
6. The regular meetings of the Association of Connecticut Tumor Clinics.
7. The formation of a special committee to complete the standard therapy outlines for cancer.

The Tumor Committee again presented a bill to the General Assembly asking for state funds to be allocated through the State Department of Health for cancer control. The Committee expects to allot these funds to the 20 Tumor Clinics to pay for diagnostic x-rays, biopsies, and radiation therapy for indigent and near-indigent patients, and administrative, and maintenance costs of the clinics. Two years ago a similar bill was presented which was turned down but this year, owing to the splendid coöperation and assistance of the Commission on the Prevention and Care of Sickness of which Doctor Creighton Barker is chairman, there is a better chance of its being passed. The Commission made a favorable recommendation to the State Legislature based on a memorandum submitted by the Tumor Committee and the cancer bill was heard before the Appropriations Committee on April 19, 1941. The Appropriation Committee entered a favorable recommendation to the Senate, but to date no further action has been taken.

The *Executive Committee*, (Doctor Charles L. Larkin, Doctor P. G. McLellan, and Doctor E. J. Ottenheimer) has again been very active carrying out the suggestions of the Tumor Committee, approving all work submitted by sub-committees, and editing all manuscripts for publication.

The Executive Committee has also been active since February 1940 in conducting a campaign in certain sections of the state to promote the annual physical examination of all persons over the age of 35 as the best means of preserving health and detecting chronic disease in its incipient form. Every physician in the following cities and towns have been approached either personally or by letter asking them to coöperate by setting up a follow-up filing system in their offices for their private patients, by which each patient is sent a follow-up card at least once a year requesting them to return for a complete physical examination. The cities are: Hartford, Waterbury, Meriden, Woodbury, Watertown, Seymour, Ansonia, Derby, Naugatuck, Shelton, East Hartford, Farmington, Canton, Glastonbury, Cheshire, Mansfield, Simsbury, Wallingford, West Hartford, Windsor, and Thomaston. Of the approximate 160 doctors who were contacted by personal letters in the cities that have been covered, 77 have started the follow-up system in their offices. The main reason why all the doctors did not comply with the request was because many of them were specializing in a particular field of medicine or surgery and a great portion of their patients were referred cases. Of the remaining approximate 500 doctors to whom a mimeographed letter was

sent, only a small number replied. Bridgeport and New Haven are in the process of being covered at the present time and there are no statistics available as yet. The follow-up cards, samples of which are attached, are printed free of charge to all physicians by the State Department of Health through the coöperation of the Division of Cancer Research, and Doctor Griswold reports that a number of requests have been made for additional cards. It is planned to communicate with every practicing physician in the state and this will be done just as quickly as possible.

This committee has spent a great deal of time bringing about and completing the recent affiliation of the Tumor Committee with the American Society for the Control of Cancer. Negotiations were carried on with the National Society during the fall of 1940. By-laws were drawn up and an agreement written, and the first meeting of the incorporators was held on December 12, 1940. The existing members of the Tumor Committee were made trustees at this meeting and 5 additional trustees were elected. The Committee was called the Connecticut State Committee of the American Society for the Control of Cancer, Incorporated. At this meeting, by-laws were adopted and the following officers elected: Doctor Charles L. Larkin, president, Doctor P. G. McLellan, secretary, Mr. Gerald C. Low, treasurer, and Mrs. Douglass O. Burnham, executive secretary and state commander of the Women's Field Army. It was decided at this meeting that the main object at the present time of this Connecticut State Committee was to supervise the organization of a Women's Field Army in the state of Connecticut under the leadership of Mrs. Douglass O. Burnham. The purpose of this Field Army is the education of lay people in the proper knowledge of cancer.

The *Scientific Committee*, (Doctor Ralph E. Kendall, chairman, Doctor E. C. Weise, Doctor John C. Mendillo, Doctor Paul Rosahn, Doctor F. A. Sutherland, Doctor K. K. Kinney, and Doctor C. J. McCormack) has been inactive during the past year but the members individually have co-operated with Doctor Griswold on the Dentists' Handbook and the classification of tumor clinics.

The *Publicity Committee* (Doctor E. J. Ottenheimer, chairman, Doctor Stanley Osborn, Doctor Carl Johnson, Doctor W. W. Dinsmore, Mr. Herbert Hirsche.) During the past year the Publicity Committee has tried to maintain the same standard as in former years. Following the publication of the cancer manual, work was started on a similar one for dentists, and some work is being done on this in collaboration with certain members of the State Dental Society. This work will probably be completed in the coming year.

In addition the Publicity Committee would like to report that during the past year 68 lectures on cancer have been given in various parts of the state. Three radio cancer talks were made, and there were 7 articles which appeared in the weekly bulletin of the State Department of Health, and 5 articles in the monthly bulletin, devoted to the subject of cancer. There were 15 news releases which were published in various papers throughout the state, and 8375 pamphlets were distributed during the past year. In addition to that, 186 requests for information relative to cancer were satisfactorily handled.

The affiliation with the American Society for the Control of Cancer which was made during the past year will probably divert a considerable amount of publicity work to that organization, and some work has been done on pamphlets which are to be distributed by the American Society, but written to a large extent by members of our own committee. While the American Society is planning, I think, on coming into the state with a great deal of publicity, it is not intended that this should not be passed upon first by our Publicity Committee.

The Division of Cancer Research. The activities of the Division of Cancer Research during the past year have been carried on with increasing tempo.

The compiling and analyzing of mortality statistics was continued and there are now on file some 37,000 punch card records of cancer death certificates. Much more detailed breakdowns of mortality statistics have been made this year than previously, and the results obtained have justified the effort. Death rates have been adjusted for age, by sexes, and a collateral study is in process at the Yale School of Public Health.

During the year, the division published a second progress report, containing a review of cancer mortality, with numerous charts and tables.

The gathering and coding of data from tumor clinics was begun, and progressed satisfactorily until depletion of the staff by the resignation on September 1, 1940 of Mr. Herbert Hirsche, our Research Statistician. Miss Eleanor Macdonald took Mr. Hirsche's place on January 20, 1941, and the work of collecting and coding clinical information has been resumed.

Visits to various clinics were made during the year and progress noted in the efficiency of their operation. Five hundred and ninety-one follow-up investigations were made for various clinics.

Preparation of a handbook on cancer for the dental profession, similar to the handbook for physicians, was started during the year, and the manuscript is now nearing completion.

The program of lay education has been carried out along lines similar to those used successfully in the past.

The accompanying table indicates the amount and scope of educational effort expended by the division:

68 Lectures	8,375 Pamphlets distributed
15 News releases	7 Weekly bulletin articles
7 Radio talks	5 Monthly bulletin articles
186 Requests for information answered	

The *Association of Connecticut Tumor Clinics* has functioned as actively as in former years. The annual meeting was held at the time of the Clinical Congress on September 21, 1940 and 4 group meetings in various hospitals throughout the state were held as follows:

October 17, Bridgeport Hospital, Bridgeport, Connecticut.

December 12, Middlesex Hospital, Middletown, Connecticut.

March 6, Grace Hospital, New Haven, Connecticut.

April 10, Charlotte Hungerford Hospital, Torrington, Connecticut.

The programs presented at these meetings are listed under the Program Committee.

Reports of the 4 sub-committees of the Association are as follows:

The Therapy Committee (Doctor Francis A. Sutherland, chairman). The purpose of this Committee is to standardize the therapeutic treatment of regional cancer in all the hospitals in this state where tumor clinics exist. The following subjects have been assigned to the various physicians listed below.

Cancer of lung and bronchus, Doctor G. Lindskog.

Cancer of larynx, Doctor Norton Canfield.

Cancer of skin, Doctor L. N. Claiborn.

Malignant lesions of the brain, Doctor William German.

Malignant lesions of spinal cord and coverings, Doctor Max Taffel.

Cancer of the bladder and prostate, Doctor C. H. Neuwanger.

Cancer of lip and tongue, Doctor William Duffy.

Cancer of oesophagus, Doctor Norton Canfield.

Malignant lesions of kidney, Doctor C. Y. Bidgood.

Malignant bone tumors, Doctor Maurice Pike.

Cancer of stomach, Doctor George Pack.

Cancer of colon and rectum, Doctor Ashley Oughterson.

All of these physicians, with the exception of one, have agreed to accept the assignments and to turn in their recommendations of therapy by April 10; the one exception is Doctor William Duffy from whom no word has been heard. Doctor Norton Canfield has already completed the assignments of cancer of the larynx and the oesophagus.

The Pathology Committee (Doctor Robert Tennant, chairman, Doctor Joseph O. Collins, Doctor L. P. Hastings, Doctor Paul D. Rosahn). The monthly informal meetings of the Pathologists of the state have been held in Brady Laboratory and have been well attended. Following a custom established two years ago of holding occasional meetings at other laboratories in the state, the March 1941 meeting was held at the Middletown State Hospital in Doctor Beauchemin's newly acquired laboratory.

The meetings as in the past have been devoted to informal presentation and discussion of interesting pathological materials as well as well as other problems concerned with laboratory function.

There has been a growing desire on the part of the members of the group to have a formal organization of the Pathologists as a division of the State Society. A constitution has been drawn up and approved by the group, although final steps for the consummation of the organization have not yet been made. The Committee wishes to express its thanks to Doctor Winternitz and his associates for their continued support and interest.

The Record Committee, (Doctor C. J. McCormack, chairman, Doctor W. B. Walker, Doctor John C. Mendillo, Doctor M. H. Griswold, Mr. Herbert Hirsche), has written up and completed a physical examination and history form which is to be used in doctors' offices throughout the state of Connecticut. This form has been submitted to and approved by the Tumor Committee. Funds will be available through the State Department of Health for the printing

of these forms so that they may be distributed free of charge to all physicians in the state who desire to use them.

The *Program Committee*, (Doctor A. W. Oughterson, chairman, Doctor Carl H. Wies, Doctor K. K. Kinney, Doctor R. T. Ogden, Doctor E. C. Weise, Doctor E. W. Foster, Doctor Paul D. Rosahn) arranged the four regular meetings of the Association of Connecticut Tumor Clinics, the first of which was held on October 17, 1940 at Bridgeport Hospital under the chairmanship of Doctor Daniel C. Patterson. The program was as follows:

- Benign Tumors of the Breast. A statistical study. Doctor John F. Nolan.
- Pathology of Benign Tumors of the Breast. Doctor W. T. Clark.
- Carcinoma of the Breast. A statistical study. Doctor W. A. Geer.
- Simple Mastectomy. A discussion. Dr. John Shea.
- Irradiation Therapy for Cancer of the Breast. Doctor B. M. Parmelee.
- Treatment of Local Recurrences and Metastases. Doctor W. L. Weadon.

The second meeting was held in Middletown at the Middlesex Hospital December 12, 1940 under the chairmanship of Doctor Carl C. Harvey. The program was as follows:

- Carcinoma of the Breast. Doctor Carl C. Harvey.
- Carcinoma of the Gastro-Intestinal Tract. Doctor Louis O. LaBella.
- Carcinoma of the Uterus. Doctor G. M. Craig.
- Case Presentations. Three Unusual Bone Tumors. Doctor Alfred N. Sweet.

The third meeting was held in New Haven at Grace Hospital March 6, 1941 under the chairmanship of Doctor Thomas H. Russell. The program was as follows:

- General Considerations regarding the Cancer Problem in Metropolitan New Haven. Doctor Wm. Mendelsohn.
- Cancer of the Stomach in Metropolitan New Haven. Doctor Ralph W. Nichols.
- Cancer of the Stomach in Grace Hospital. Doctor Samuel Spinner.
- The Role of Radiology in Cancer of the Stomach. Doctor Wm. G. H. Dobbs.

The fourth and last meeting is being held on April 10, 1941 at the Charlotte Hungerford Hospital, Torrington, under the chairmanship of Doctor Francis A. Sutherland. The program is as follows:

- Carcinoma of the Mouth. Doctor Emerson S. Hill.
- Carcinoma of the Cervix and Uterus. Doctor Floyd A. Weed.
- Early Carcinoma of the Cervix. Doctor Paul A. Young.

Plans for the program to be held during the Clinical Congress in September 1941 are being formulated by the Committee. Fifteen-minute papers will be presented during each morning session by out-of-town doctors who have had experience in oncology.

The *Radium Lending Committee* has been dissolved as its period of usefulness has terminated.

The *Connecticut State Committee of the American Society for the Control of Cancer, Inc.*, has met twice since its in-

corporation and will hold another meeting on April 10. Copies of the articles of association, the by-laws and the agreement between the American Society for the Control of Cancer and the Tumor Committee are attached herewith. This committee, being mainly composed of the members of the State Tumor Committee, has continued to carry out the objects of said committee and in addition is in the process of supervising the organization of the Women's Field Army by the State Commander, Mrs. Douglass O. Burnham, whose reports on what has been accomplished so far follows:

On January 2, 1941 after a conference with Mrs. Harry W. Smith, regional deputy commander of the New England States, the first steps were taken in the organization of a lay group of women to carry on a year round educational and publicity program for the purpose of teaching the public that early cancer is curable and that knowledge is the best means by which it can be prevented and detected in the early stages.

During the month of January about fifty key-women throughout the state were contacted either by letter or personally.

A Regional Assembly of the Women's Field Army was held in Providence on January 23 and 24, which was attended by officials of the Field Army from Connecticut including Doctor Charles L. Larkin, Doctor E. J. Ottenheimer, and Mrs. Douglass O. Burnham.

Vice commanders have been appointed for 10 districts out of 30. These districts are: Waterbury, Westport, Stamford, Bristol, Torrington, Meriden, Bridgeport, Newington, Norwich, and Goshen. These 10 districts are in the process of organization and have publicity directors, medical advisors, medical speakers, and captains. These districts are conducting a campaign for funds the last week in April through mailing lists. A full publicity campaign will be carried on.

The proclamation of cancer month by Governor Robert A. Hurley was released throughout the state on April 4 and publicity directors were instructed to have cancer month proclaimed locally.

The attached pamphlet was written and edited by the Connecticut State Committee of the American Society for the Control of Cancer to be distributed in the 10 organized districts. A booklet also written by the Connecticut State Committee entitled "What the Layman Should Know About Cancer", is in the hands of the printers. Additional literature and items for publicity have been purchased from the National Society and distributed to the 10 organized districts.

A meeting of the existing vice commanders and captains was held in Waterbury on March 12. Mrs. Harry W. Smith from New Hampshire spoke on the organization of the Field Army. The attendance was necessarily small because of a blizzard. A district meeting of workers was held in Bristol April 2, and in Meriden April 3. A district meeting of workers will be held in Waterbury April 9 and April 14 in Westport, and one is being planned in Stamford, New Haven, Bridgeport, and Torrington in the near future.

Small committees have been formed in the cities of New Haven and Hartford to assist in choosing city commanders, (the other two largest cities in the state, namely, Waterbury and Bridgeport being already organized). Of the remaining

18 districts every one has been contacted in the attempt to obtain a vice commander; 10 are at present still in the works; 8 are for the moment inactive. All the doctors on the Connecticut State Committee are coöperating to obtain or suggest key women for these positions. A doctor has been appointed in every district to act as medical advisor to the local vice commander.

REPORT OF MEDICAL EXAMINING BOARD

Mr. President and Gentlemen of the House of Delegates:

The thirty-seventh annual congress on medical education and licensure was held in Chicago on February 17 and 18. It was largely attended by representatives from all parts of the United States. Many important and interesting subjects were covered. Doctor Samuel C. Harvey a member of this society read a paper entitled, "The Objective of Medical Education." It was very well received. The Reverend M. F. Griffin, Trustee of the American Hospital Association in a paper warned of the changing attitude of the courts and juries in malpractice suits. Colonel Leonard S. Rowntree, Chief of the Medical Division, Selective Service System read a paper on the physician in Selective Service. This was widely and critically discussed. For one familiar with previous meetings this session emphasized the fact so well known to many of us that medical practice and the laws and rules governing it are rapidly changing.

The Medical Examining Board admitted to its examinations during the past year one hundred and eighty-six applicants. Of this number, one hundred and four wrote the examinations and eighty-two were admitted to the examination on the basis of credentials. There was a total of sixty-five failures or almost thirty-five percent. Three osteopaths appeared for examinations; one wrote medicine three times and failed and two wrote medicine and surgery once and failed.

The Committee, functioning as a Complaint Board, held three special meetings during the year. At these meetings four physicians appeared on major complaints.

Respectfully submitted,
T. P. Murdock, M.D., Secretary.

REPORT OF COMMITTEE TO STUDY THE MEDICAL EXAMINER SYSTEM

To the House of Delegates:
Gentlemen:

I have the honor to submit herewith a report of your committee to study the Medical Examiner System.

Since the submission of the last report the then Chairman, Doctor Stanhope Bayne-Jones, tendered his resignation which was accepted by the Council and appointed me to be Chairman and Doctor M. M. Scarbrough was named as a member of the committee.

The Executive Secretary notified the Committee on December 13, 1940 that the Council had adapted the previous report and instructed him to introduce bills into the legislature to accomplish the recommendations contained therein.

January 30, 1941 action was taken to recommend amendment of Chapter 179 of the General Statutes, Section 2399 as amended by 1045 E of the Public Acts of 1939.

Section 1045e of the Public Acts of 1939 is amended:

CREMATION AUTHORIZED. The body of any deceased person may be disposed of by incineration or cremation in this state, or may be removed from the state for such purpose. In any such case, the certificate of death required by law shall be filed with the registrar of vital statistics, together with a certificate under oath, . . . from the medical examiner or coroner of the town where the death occurred that he has viewed the body and made personal inquiry into the cause and manner of death and is of the opinion that no further examination or judicial inquiry concerning the same is necessary. Upon receipt of such certificate the registrar shall issue a permit for the cremation of such body; but in no case shall any body be cremated until at least forty-eight hours after death unless such death was the result of contagious or infectious disease; and no body shall be received by any crematory unless accompanied by the permit provided for in this Section. *The State Department of Health* shall provide forms for such permits, which shall not be the same as for the regular burial permits, and such blanks and books as may be required by the registrars.

A meeting of the committee was held on March 4, 1941 and was attended by the Executive Secretary whose advice and help was of material aid. It was decided to postpone further study of the Medical Examiner System until the attitude of the legislature on the proposed bills was ascertained. It was also decided that members of the committee should appear in behalf of these bills at their respective legislative committee hearings. This was done and the Executive Secretary and State Health Officer also testified. No person appeared in opposition to the bills.

Further discussion was had of the establishment of a department of toxicology capable of criminal investigation and it was voted to obtain further information concerning costs, probable personnel and situation.

Respectfully submitted,
Edward H. Kirschbaum, M.D., Chairman.

REPORT OF CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION 1940-1941

To the House of Delegates:
Gentlemen:

Your Conference Committee with the Connecticut Pharmaceutical Association was formed immediately following the last annual meeting of this Society. The first meeting of the Committee was held in Hartford on June 4 and there have been two successive meetings in New Haven. The chairman of the Committee, as you will note, is from the medical group in the Committee while the secretary, Mr. John Dugan of New Haven, is one of the Pharmaceutical Association representatives.

Very few other such committees are known to be in existence today, notably one in Westchester County, New

York, so that the program of our Committee must necessarily be developed along lines for the most part originated within ourselves. There are many problems in Connecticut common to both medicine and pharmacy with which this Committee is attempting to deal. With this end in view a set of Principles and Recommendations has been formulated and already accepted by the Connecticut Pharmaceutical Association. Our own Council has been unwilling to accept the same without certain changes.

This Committee is making an effort through proper publicity in the pharmacies of the State to direct people in need of medical treatment to the places where they may best obtain such treatment. At the same time, by the use of editorials in the Connecticut State Medical Journal and by the supplying of speakers from each profession at meetings of the other profession the Committee is endeavoring to call the attention of physicians and pharmacists to common problems and their solutions.

Members of this Committee have been generous with their time and suggestions. The outlook for effective accomplishment is most favorable.

Respectfully submitted,

Stanley B. Weld, M.D., Chairman.

REPORT OF THE COMMITTEE TO REVISE THE MEDICAL PRACTICE ACTS

The Connecticut Medical Examining Board was designated as the Committee from this Society to study the medical practice laws of the State and, if necessary, to propose revision of those laws in order that the administration and application of the medical practice laws might be clarified and improved.

The Committee which consists of Charles J. Bartlett, President, Thomas P. Murdock, Secretary, John C. Rowley, George M. Smith and Daniel C. Patterson with the Executive Secretary of the Society, engaged upon a detailed study of the medical practice acts. Out of experience covering many years there were some details in the existing law that the Board believed should be revised in order to provide more satisfactory administration. These changes were set down and also it was provided in the proposed legislation that candidates for license to practice medicine in this State in the future should be citizens of the United States. After the deliberation of the Board were completed the Executive Secretary took the proposed draft of the statutes to Chicago where a conference was held with Mr. J. W. Holloway of the Bureau of Legal Medicine of the American Medical Association, who was most helpful in revising phraseology. Finally the proposed amendments to the laws were published in the Connecticut State Medical Journal in December 1940, were submitted to the Special Meeting of the House of Delegates on December 12, 1940 where approval was given, and the measures were introduced to the General Assembly of 1941. Hearings on the measure were held before the Committee on Public Health and Safety on April 3rd. At the time of writing this report the Committee has not reported on the measure.

Respectfully submitted,

Charles J. Bartlett, M.D., President.

REPORT OF COMMITTEE ON NATIONAL LEGISLATION

In view of the comprehensive reviews of national legislation which have been presented from time to time in the Journal of the American Medical Association and recently also in the April number of the Connecticut State Medical Journal, no detailed report of your committee appears to be called for. Members of the Connecticut State Medical Society will be kept informed of opportunities which may occur to bring individual views on medical legislation to the attention of our senators and representatives in Washington.

Respectfully submitted,

George Blumer, M.D.,

James R. Miller, M.D.

REPORT OF THE COMMITTEE ON NARCOTIC DRUG ADDICTION

There has been considerable discussion as to the advisability of including paregoric and other opium containing preparations in the list of narcotics limited to written prescriptions. Our state narcotic agent has urged this for several years as a further means of controlling narcotic addicts. At present, this question has been revived on the recommendation of Commissioner H. T. Anslinger of the Federal Narcotic Bureau. In the interests of national defense and conservation of present supplies of opium, he urges an amendment to the Uniform Narcotic Act in all the states, eliminating all the narcotic exemptions with the exception of codeine. This will mean that paregoric and many proprietary preparations will be limited to prescription. This was submitted to the legislature by the State Department of Health and now, in the form of Senate Bill 820, is awaiting action.

Another problem before the Committee is the question of the promiscuous use of the barbiturates. Our present State Food, Drug and Cosmetic Act allows any person to purchase these drugs without restriction. There is a growing feeling that they should be limited to written order by the physician. Studies already made show that the barbiturates are responsible for many suicides, attempted and accomplished, and that addiction is becoming increasingly frequent. Barbiturate addicts make up about one-tenth of all drug addicts received by the hospitals in our larger cities. Evidence suggests their probable involvement in many automobile accidents and criminal assaults. According to the American Medical Association Bureau of Legal Medicine, twenty-seven states already have laws limiting the sale of barbiturates to written prescription. While there is a strong feeling by some that this is also a real problem in Connecticut, no one knows the actual facts of the situation. A questionnaire is being prepared which will be submitted to the doctors, hospitals and pharmacists of the state by which it is hoped to determine: (1) the approximate number of barbiturate poisoning cases per year; (2) the approximate number of barbiturate addicts seen by doctors and pharmacists per year; (3) the percentage of patients who use some form of barbiturates periodically or habitually; (4) the actual amount of barbiturates prescribed or dispensed per year; and (5)

whether the physicians and pharmacists feel that the use of barbiturates is being abused and should be limited to prescription.

It is hoped that the doctors will answer the questionnaire promptly and make additional comments as to experiences with the drug in their own practices. Recommendations as to any legislative action will await the result of this study.

For the Committee,
John H. Foster, M.D., Chairman.

REPORT OF COMMITTEE ON BY-LAW REVISION

To the House Delegates:

Gentlemen:

Early in its study of a Revision of the Constitution and By-Laws of this Society your Committee found that certain provisions in its organization were not within the jurisdiction of the Society as they were incorporated in the Charter (sections 2, 3, 4, 5, 6, 7) enacted by the Senate and House of Representatives in 1939, and these provisions for its organization and government could only be changed by petition to the General Assembly.

Your Committee has made a study of the original Charter granted to this Society in 1792 and of adjustments made to meet the demands of changing conditions to the present time and thoroughly appreciates the historic value of the Charter and accomplishments under it for the benefit of the State and advancement of medicine.

Within recent years amendments have related largely to matters that should be included, properly, in the Constitution and By-Laws of the Society and the Legislature should not be burdened with their consideration.

Recognizing the close relationship of the State and medicine we recommend that the Charter be *not relinquished* but that it be simplified to the statement of the name of the organization, its purposes, and empower it to operate under such a Constitution and By-Laws as shall enable it to carry out those purposes.

It is obvious that a thorough revision of the Constitution and By-Laws of the Society cannot be satisfactorily accomplished until the Society has had an opportunity to express itself relative to its Charter under which it is now operating. The fact that in the next year the Society is celebrating its sesquicentennial makes it a peculiarly fitting time to make readjustment.

In 1934 a Special Committee of the House of Delegates of the American Medical Association submitted a model for Constitution and By-Laws to be referred to constituent State and Territorial Associations for their consideration. This model has been submitted to us and appears to lend itself to adaptation to meet the needs of the Connecticut Society. It would have the advantage as being, in the main, in harmony with the constitutions of other associations composing the American Medical Association.

This same situation exists relating to our own constituent societies, the County Associations. On assembling the constitutions of the various County Associations it became apparent that there was not a uniformity in their construction and

some of the discrepancies tend to interfere with smoothness and accuracy in our own state office. It would therefore seem desirable to determine the willingness of the County Associations to participate in the effort to bring about uniformity in the fundamentals of their county constitutions before a general reconstruction is actually begun.

Respectfully submitted,
Cole B. Gibson,
Thacher W. Worthen,
William M. Shepard,
Charles G. Barnum,
D. Chester Brown, Chairman.

REPORT OF PROGRAM COMMITTEE

House of Delegates:

Gentlemen:

The Program Committee, Francis Blake, Berkley M. Parmelee, and myself, has had, to date, a minimum of difficulties, largely because of the pleasant and capable coöperation of our Executive Secretary. At an early committee meeting it was agreed that the specialty sections of the Society deserved their turn to nominate speakers. From such nominations the speakers for the May meeting were chosen. Acceptances for the entire program were in the Executive Secretary's office by early March. We have been embarrassed since by having to refuse excellent suggestions for the program because of lack of available time.

I wish to express my gratitude for the able assistance of Doctors Blake and Parmelee, and particularly to Miss Helen Grove and Creighton Barker without whose assistance the Program Committee chairmanship would be a monumental task.

G. Gardiner Russell, Chairman.

FINAL REPORT OF THE COMMITTEE ON MEDICAL EXPERT TESTIMONY

Since our previous report, your Committee has continued to function and has maintained contact with the Special Committee of the State Bar Association.

Last fall it was the combined opinion of the two committees that legislation be presented to the 1941 Legislature based upon the Uniform Expert Testimony Act, approved by the American Bar Association. Subsequently House Bill 662, an act concerning expert testimony, was introduced into the 1941 General Assembly by the Honorable William L. Hadden, Representative from West Haven. This Bill, with minor changes, incorporated the text of the Uniform Expert Testimony Act.

At a hearing held before the Judiciary Committee at the State Capitol in Hartford on Thursday, March 27, 1941, your Committee was represented by two of its members and the chairman spoke in favor of the Bill.

Should Bill 662 be passed, it is our opinion that numerous evils regarding expert testimony will be eliminated.

Respectfully submitted,
Otto G. Wiedman, M.D., Chairman.

REPORT OF THE ADVISORY COMMITTEE OF THE CONNECTICUT STATE MEDICAL SOCIETY TO THE BOARD OF EXAMINERS FOR NURSING FOR THE YEAR 1940

The Board of Examiners for Nursing and Advisory Committee met on the following dates: February 29, May 27, June 20, September 13, October 22, and November 15, 1940.

The meetings have been mainly concerned with the discussion relative to:

1. Problems relative to the close of the waiver for trained attendants.
2. The organization of further courses for subsidiary workers.
3. Clarifying problems relative to the administration of the present Act in order to obviate the necessity for further statutory changes at this time.

Respectfully submitted,
B. Austin Cheney, M.D.

REPORT OF THE COMMITTEE TO STUDY OSTEOPATHIC LEGISLATION

The Committee has had no meetings since its report to the House of Delegates at the annual meeting in 1940. The Committee was continued for the purpose of meeting the necessity of osteopathic legislation which might be proposed to the 1941 General Assembly. At the time of the writing of this report the osteopathic program in the 1941 General Assembly is uncertain.

Berkley M. Parmelee, M.D., Chairman.

REPORT OF COMMITTEE ON WORKMEN'S COMPENSATION

Despite our earnest desires to be as active as possible with the work of the compensation committee, we have found that times have changed rather acutely in this country necessitating a great deal of extra work for most of the members of the committee. Obviously, I refer to the expansion of this country's defense program and to the induction of civilians for military training, the examinations of whom have required a great deal of time of many physicians. The committee held a meeting at the Graduates Club on September 19, 1940, at which time eight of the ten members were present. Various features of compensation in the various localities represented by the members were briefly discussed. Among these features a few might be mentioned, namely, a clarification of the law in regard to hernia so that an employee would not have to be the subject of a situation which is now required by the law. This concerns the subjective and objective manifestations of pain in connection with an injury, etc. Secondly, a fee table. Third, the matter of doctors being selected as compensation commissioners.

The committee has publicized its existence in the Connecticut State Medical Journal and also in the sections of the Journal devoted to County News with the idea that

if there were any complaints or problems in connection with the act we would receive them for consideration and action if necessary and possible. We have received but one complaint and this was of a relatively minor nature which did not involve any broad principles in regard to compensation. The committee has also notified the various commissioners of compensation of its existence and requested aid from them and have placed themselves available for consultation in regard to matters concerning compensation. We have had no functioning as a committee with any of the commissioners, although letters were received from several commissioners acknowledging their thanks for the formation of the present committee and for any aid they might want to obtain from it.

No members of the committee have presented any complaints or problems concerning the compensation law in their respective sections of the State. From the above you will understand that we have asked for any matters of a troublesome nature and have received none. Time, or rather the lack of time, has prevented us as a committee from seeking out difficulties in regard to the working of the compensation law. All of this would lead one to believe that there are not too many complaints or any complaints of magnitude although we are all aware of complaints of a relatively minor nature.

Very truly yours,
Benedict B. Landry, M.D., Chairman.

REPORT OF COMMITTEE ON HOSPITALS

Gentlemen of the House of Delegates:

Your Committee has nothing to report, as there have been no meetings held during the fiscal year. Your Chairman has attended as an accredited delegate, meetings of the Connecticut Hospital Association.

Very truly yours,
H. Bertram Lambert, M.D., Chairman.

REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE SCHOOL OF MEDICINE

During the year 1940-41 nothing has occurred to disturb the cordial relationships which have always existed between the Yale School of Medicine and the Connecticut State Medical Society. It has, therefore, been unnecessary to call the Committee for a meeting.

Respectfully submitted,
James R. Miller, Chairman.

REPORT OF THE COMMITTEE ON HONORARY MEMBERS AND DEGREES

The Committee presents no recommendations for honorary membership in the Society at this time.

Charles H. Turkington, M.D., Chairman.

SESSQUICENTENNIAL CELEBRATION PLANNING COMMITTEE

This is a report of the progress of the Planning Committee for the Sesquicentennial Celebration to be held in 1942. The Planning Committee was appointed by the Chairman of the General Committee, Doctor Blumer, in accordance with a vote passed at its first meeting on October 29, 1940. Those appointed to serve on this committee are as follows:

Chairman, Herbert Thoms, Daniel Sullivan, Peter J. Steincrohn, Roy L. Leak, James D. Gold.

Ex Officio, George Blumer, James R. Miller, Stanley B. Weld, Creighton Barker.

The following proposals for the Celebration have been made by this committee and are subject to change and a final confirmation by the General Committee. The Planning Committee believes it advisable to adhere to the decision made by the House of Delegates of the Society and recommends that the Celebration be held in the City of Middletown using the campus and buildings of Wesleyan University for part of the ceremonies and the dining room and theater at the Connecticut State Hospital. The committee recommends that the celebration be held the third week of June in 1942. The committee is not unmindful of the historic interest in having the celebration on the exact date of the founding of the Society, which is October 9th, but because of various conflicts liable to occur at that time it is believed that the June date is advisable. The day of the week has not been decided but Saturday has been favorably considered. It is suggested that the ceremonies commence at ten or ten thirty in the morning, and an opportunity will be given for members and guests to view historical exhibits, the formal exercises to start at 11:00 A. M. It is suggested that these formal exercises be comprised of a program which would include a brief address of welcome by the President of the Society, remarks by the Governor of Connecticut and the President of Wesleyan University, and the Mayor of Middletown. This will be followed by three short addresses by members of the State Medical Society on various phases of the historical development of the Society. Luncheon will be served out of doors if the weather permits, following which a brief recess will give opportunity to visit the historical and other exhibits. In the mid afternoon the Society will be in convocation to receive delegates from the medical societies of the other New England States, and at this time the oration of the day by an invited speaker will be given. In the late afternoon a reception of the officers of the society and the distinguished guests will be held in the Wesleyan Library. In the evening the banquet will be held in the Assembly Hall of the Connecticut State Hospital, to be followed by brief addresses by distinguished guests, the President of the American Medical Association, representatives of the Army, Navy, etc., and the address of the evening by an invited speaker. In addition to this program it is proposed to have exhibits on view which will emphasize the history of medicine in Connecticut and certain educational exhibits which will be of general interest.

The following Chairmen of subcommittees have been appointed and have expressed their willingness to serve:

Local Committee on Arrangements, Doctor Roy C. Leak.

Committee on Promotion and Publicity, Doctor C. C. Burlingame.

Committee on Historical Program, Doctor David R. Lyman.

Committee on Banquet, Doctor Roy C. Leak.

Committee on Loan Exhibits, Doctor Arthur H. Jackson.

Committee on Hospitality, Doctor James R. Miller.

Herbert Thoms, Chairman Planning Committee,

The Committee on the Sesquicentennial
Celebration.

SULFATHIAZOLE TREATMENT OF GONOCOCCUS INFECTIONS

(Continued from page 346)

Marine Hospital, Staten Island, N. Y.

2. Carpenter, C. M., Leahy, A. D. and Wilson, K. M. Comparison of results of smear and cultural methods for diagnosis of gonococcal infections in adult females, *Am. J. Syph.*, 1938, 22:25.
3. Vonderlehr, R. A., Administrative Problems in the Control of Gonococcal Infections, Page 169—Transactions of the American Neisserian Society, June 1939.
4. Pelouze, P. S., et al.: *J.A.M.A.* Nov. 9, 1940, Page 1633.
5. Mahoney, J. F., Wolcott, R. R., and Van Slyke, C. J.: *Amer. Jour. Syph., Gonorr. & Ven. Dis.*, 24:613, Sept., 1940.
6. Ballenger, E. G.; McDonald, H. P., and Coleman, R. C.: *South. Med. Jour.*, 33:911, Sept., 1940.
7. Burkholder, T. M., and Bang, F.: *Jour. Urol.*, 44:541, Oct., 1940.
8. Culp, O. S.: *Jour. Urol.*, 44:367, Sept., 1940.
9. Harkness, A. H.: *Lancet*, 2:250, Aug. 24, 1940.
10. Lloyd, V. E., and Erskine, D.: *Lancet*, 2:186, Aug. 17, 1940.
11. Mitchell, D. R., Greig, C. H., and Uren, J. L.: *Canad. Med. Assn. Jour.*, 42:533, June, 1940.
12. Stirling, W. C.: *J.A.M.A.*, 115:118, July 13, 1940.
13. Miescher, Schweiz. *Med. Wchnschr.* 70:621 (June 29) 1940.

Summer Diarrhea in Babies

Casec (calcium caseinate), which is almost wholly a combination of protein and calcium, offers a quickly effective method of treating all types of diarrhea, both in bottle-fed and breast-fed infants. For the former, the carbohydrate is temporarily omitted from the 24-hour formula and replaced with 8 level tablespoonfuls of Casec. Within a day or two the diarrhea will usually be arrested, and carbohydrate in the form of Dextri-Maltose may safely be added to the formula and the Casec gradually eliminated. Three to six teaspoonfuls of a thin paste of Casec and water, given before each nursing, is well indicated for loose stools in breast-fed babies. Please send for samples to Mead Johnson & Company, Evansville, Indiana.

SPECIAL NOTICES

COMING MEETINGS

Connecticut State Medical Society, Bridgeport, May 21-22.
 Doctor Creighton Barker, 258 Church St., New Haven, Secretary.

Maine Medical Association, York Harbor, June 22-24. Doctor F. R. Carter, Augusta, Secretary.

Massachusetts Medical Society, Boston, May 21-22. Doctor Robert N. Nye, 8 Fenway, Boston, Secretary.

New Hampshire Medical Society, Manchester, May 13-14. Doctor Carleton R. Metcalf, 5 South State St., Concord, Secretary.

New Jersey, Medical Society of, Atlantic City, May 20-22. Doctor Alfred Stahl, 55 Lincoln Park, Newark, Secretary.

Rhode Island Medical Society, Providence, May 28-29. Doctor Guy W. Wells, 124 Waterman St., Providence, Secretary.

American Association of Genito-Urinary Surgeons, Hot Springs, Va., May 29-31. Doctor Charles C. Higgins, 2020 East 93d St., Cleveland, Secretary.

American Association for the Study of Goiter, Hotel Statler, Boston, May 12-14. Doctor W. Blair Mosser, 133 Biddle St., Kane, Pa., Secretary.

American Association of the History of Medicine, Atlantic City, N. J., May 4-6. Doctor Henry E. Sigerist, 1900 East Monument St., Baltimore, Secretary.

American Gastro-Enterological Association, Atlantic City, N. J., May 5-6. Doctor Thomas T. Mackie, 16 East 90th St., New York, Secretary.

American Gynecological Society, Colorado Springs, May 26-28. Doctor Richard W. TeLinde, Johns Hopkins Hospital, Baltimore, Secretary.

American Laryngological Association, Atlantic City, May 28-30. Dr. Charles J. Imperatori, 108 East 38th St., New York, Secretary.

American Ophthalmological Society, Hot Springs, Va., May 29-June 1. Doctor Eugene M. Blake, 303 Whitney Ave., New Haven, Conn., Secretary.

American Otological Society, Atlantic City, N. J., May 26-28. Doctor Isidore Friesner, 36 East 73d St., New York, Secretary.

American Psychiatric Association, Richmond, Va., May 5-9. Doctor Arthur H. Ruggles, 305 Blackstone Blvd., Providence, R. I., Secretary.

American Society for Clinical Investigation, Atlantic City, N. J., May 5. Dr. Eugene M. Landis, University of Virginia Hospital, Charlottesville, Va., Secretary.

American Society of Clinical Pathologists, Cleveland, May 30-June 1. Doctor A. S. Giordano, 531 North Main St., South Bend, Ind., Secretary.

American Therapeutic Society, Cleveland, May 30-31. Doctor Oscar B. Hunter, 1835 Eye St. N.W., Washington, D. C., Secretary.

American Urological Association, Colorado Springs, Colo., May 19-22. Doctor Clyde L. Deming, 789 Howard Ave., New Haven, Conn., Secretary.

Association for the Study of Internal Secretions, Atlantic City, N. J., May 2-3. Dr. E. Kost Shelton, 921 Westwood Blvd., Los Angeles, Secretary.

Association of American Physicians, Atlantic City, N. J., May 6-7. Dr. Hugh J. Morgan, Vanderbilt University Hospital, Nashville, Tenn., Secretary.

Medical Library Association, Ann Arbor, Mich., May 29-31. Miss Anna C. Holt, 25 Shattuck St., Boston, Secretary.

National Gastroenterological Association, New York, May 13-16. Doctor G. Randolph Manning, Room 319, 1819 Broadway, New York, Secretary.

National Tuberculosis Association, San Antonio, Tex., May 5-8. Doctor Charles J. Hatfield, 1790 Broadway, New York, Secretary.

Society for the Study of Asthma and Allied Condition, Atlantic City, N. J., May 3. Doctor W. C. Spain, 116 East 53d St., New York, Secretary.

THE SECOND AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The Second American Congress on Obstetrics and Gynecology will be held in St. Louis, Missouri, April 6 to 10, 1942. All of the meetings and both the Commercial and Educational and Scientific Exhibits will be held in the Public Auditorium.

The general plan for the program will be much the same as that of the first Congress, which was held in Cleveland, September 11-15, 1939, with sectional meetings for the various groups (nurses, public health, administrators, educators, and physicians), general sessions for all members attending the Congress and round tables. There will be evening sessions open to the general public.

Adequate time for registration will be given the first day, before the opening of the sessions of the Congress. Admission to the Congress will be by individual membership card only. These may be secured by payment of the five dollar registration fee, any time after September 1, 1941.

At the suggestion of the Medical Exhibitors Association, more time will be allowed for the members of the Congress to visit the Exhibits. The response to a letter sent to the firms handling products of interest to our group telling them of a second Congress has been excellent and we are assured of an excellent Commercial Exhibit.

The hotel headquarters have not been assigned to the various groups as yet, but the Medical Section and General Congress Headquarters will be in the Jefferson Hotel.

For further information, apply to the Chicago office of the Congress, 650 Rush Street.

A. M. G. A. GOLF TOURNAMENT, JUNE 2

The American Medical Golfing Association will hold its twenty-seventh annual tournament at Cleveland Country Club and Pepper Pike Club in Cleveland, Ohio on Monday, June 2, 1941. Members may tee off from 7:30 A. M. to 2 P. M.

Fifty Trophies and Prizes:

Thirty-six holes of golf will be played in competition for the fifty trophies and prizes in the eight events. Trophies will be awarded for the Association Championship, thirty-six holes gross, the Will Walter Trophy; the Association Handicap Championship, thirty-six holes net, the Detroit Trophy; Championship Flight, First Gross, thirty-six holes, the St. Louis Trophy; Championship Flight, First Net, thirty-six holes, the President's Trophy; Eighteen Hole Championship, the Golden State Trophy; Eighteen Hole Handicap Championship, the Ben Thomas Trophy and the Atlantic City Trophy; Maturity Event, limited to Fellows over 60 years of age, the Minneapolis Trophy; and the Old-guard Championship, limited to competition of past presidents, the Wendell Phillips Trophy. Forty other prizes will be awarded for the various flights.

Fellows in Every State in the Union:

Doctor David H. Houston of Seattle, Washington is President, and Doctor Harry E. Mock of Chicago and Doctor James Craig Joyner of New York are Vice-Presidents of the A.M.G.A., which was organized in 1915 by Doctors Will Walter, Wendell Phillips and Gene Lewis and totals 1,643 members representing every state in the Union. The living past presidents include Doctors Thomas Hubbard of Toledo, Fred Bailey of St. Louis, Robert Moss of LaGrange, Texas, Charlton Wallace of New York, Will Walter of Evanston, Illinois, James Faves of Oakland, California, D. Chester Brown of Danbury, Conn., W. D. Sheldon of Rochester, Minn., Walter Schaller of San Francisco, Edwin Zabriskie of New York, Frank A. Kelly of Detroit, John Welsh Croskey of Philadelphia, Homer K. Nicoll of Chicago, Charles Lukens of Toledo, M. M. Cullom of Nashville, Tenn., W. Albert Cook of Tulsa, Okla., Walt P. Conaway of Atlantic City, E. S. Edgerton of Wichita, Kan., and George W. Hall of Chicago.

Doctor John B. Morgan Heads Cleveland Golf Committee:

The Cleveland Golf Committee is under the able Chairmanship of Doctor John B. Morgan, 1822 Republic Bldg., Cleveland, who headed the golfing group when the A.M.A. met in Cleveland in 1934. He will be assisted by Doctors William J. Engel, Farrell T. Gallagher and F. W. Merica.

Two Eighteen-Hole Championship Courses:

The twenty-seventh tournament of the American Medical Golfing Association at the Cleveland Country Club and Pepper Pike Club promises to be a wonderful affair. The two courses are of championship calibre, and the clubhouse of the Cleveland Country Club, where the golfers' banquet will be held at 7:00 P. M., is one of the most beautiful and elaborately spacious in the country. The AMGA officers anticipate that some 250 to 300 medical golfers from all parts of the United States will play thirty-six holes in Cleveland on June 2.

Application for Membership:

All male Fellows of the American Medical Association are eligible and cordially invited to become members of the AMGA. Write Executive Secretary Bill Burns, 2020 Olds Tower, Lansing, Mich., for application blank. Participants in the AMGA tournament are required to present their home club handicap, signed by the club secretary, at the first tee on the day of play. No handicap over 30 is allowed. Only active Fellows of the AMGA may compete for prizes. No trophy is awarded a Fellow who is absent from the annual dinner, which is always worthwhile waiting for!

NATIONAL GASTROENTEROLOGICAL ASSOCIATION

The Sixth Annual Convention of the National Gastroenterological Association will be held at Hotel Commodore, New York City, May 13-16, 1941. The program includes such subjects as "Aluminium Hydroxide vs. Gelatin in the Treatment of Hypertrophic Gastritis;" "Spastic Constipation;" "Underweight: A Problem in Treatment;" "The Inactivation of Pepsin and its Relation to Peptic Ulcer;" "The Diagnosis of Functional Dyspepsia;" "Ulcerative Colitis;" "The Influence of Endocrines in Gastro-Intestinal Symptomatology;" "Peritoneoscopy;" "Cardiospasm;" "The Physiology of Enterocrinin;" and "Some Phases of Common Duct Surgery."

Speakers include S. A. Komarov of McGill University, George M. Curtis of Ohio State University, Ralph Pemberton of University of Pennsylvania, Hugh Auchinloss of Columbia University, Charles D. Snyder of Johns Hopkins University, Frank H. Lahey of Boston, Frederic V. Hussey of Providence, and Louis H. Clerf of Jefferson Medical College.

Members of the medical profession are cordially invited. The secretary is G. Randolph Manning, M.D., New York City.

EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Cleveland, Ohio, by the entire Board from Wednesday, May 28, to Monday, June 2, 1941, inclusive, prior to the opening of the annual meeting of the American Medical Association in Cleveland.

Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *reexamination* in Part II must make written application to the Secretary's Office before April 15, 1941.

The Board requests that all prospective candidates who plan to submit applications in the near future request and use the new application form which has this year been inaugurated by the Board. The Secretary will be glad to furnish these forms upon request, together with information

regarding Board requirements. Address Doctor Paul Titus, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

This Board will hold its annual dinner for Diplomates, and others interested in the work of the Board, on Wednesday evening, June 4, 1941, at the Wade Park Manor Hotel, Cleveland, Ohio, immediately following the close of the Part II examinations. Diplomates certified at the preceding days' examinations will be introduced personally, and there will be several speakers.

Tickets at \$3.25 each may be obtained from Doctor Joseph L. Baer, chairman, 104 S. Michigan Avenue, Chicago, Illinois, or at the Registration Desk during the examination period.

Free Copies of T. B. Manual Available

As a part of the nationwide Early Diagnosis Campaign, the Connecticut Tuberculosis Association is offering to any interested physician, a free copy of a 48 page illustrated manual on "Chest X-ray Interpretation." To aid the general practitioner in acquiring a better understanding of the problems involved in roentgenologic studies, this brochure, prepared by J. Burns Amberson, M.D., for the National Tuberculosis Association, presents a detailed discussion of technical matters regarding standardization and various factors and methods that influence the quality and uniformity of roentgenograms.

Wm. D. Cutler, M.D., secretary, Council on Medical Education, A.M.A., says in the foreword: "This timely brochure will be invaluable to physicians engaged in the diagnosis and treatment of tuberculosis, but in no sense diminishes the need for that expert radiologic consultation which is still an essential feature of the medical service."

A free copy may be had upon request to the Connecticut Tuberculosis Assn., 43 Farmington Ave., Hartford. A postcard will be sufficient.

A Certifying Board of Industrial Medicine

Doctor Clifford Kuh, Chairman, Committee on Industrial Health, Connecticut State Medical Society, has been personally advocating for over a year that the Advisory Board of Medical Specialties organize an American Board of Industrial Medicine for certification of industrial specialists. He has just

been advised that the formation of such a board as a new board within the framework of the American Board of Internal Medicine will be considered at the forthcoming annual meeting of the latter board.

The Birth Control Law Challenged

Connecticut's sixty-two year old birth control statute is once more the subject of litigation in a suit filed in the Superior Court of New Haven County in March by Doctor Wilder Tileston, professor of clinical medicine at Yale. This suit, designed to test in advance the constitutionality of a statute, calls for a declaratory judgment and is an odd and unusual legal procedure. In bringing this action through his attorney, Doctor Tileston cited the cases of three patients in whom further pregnancies would be harmful and perhaps fatal. The suit charges that denial of the right to give his patients contraceptive advice would be unconstitutional under both state and federal constitutions since it would abrogate the principle of liberty, security of person, privileges and immunities of citizens of the United States, and deprive a person "of life without due process of law."

Under the ruling of the Supreme Court of Errors in the Waterbury case early in 1940, Connecticut physicians have been faced with the alternative of either turning away mothers to whom another pregnancy might bear permanent injury to health or even produce death, or of subjecting themselves to possible criminal prosecution. Doctor Tileston expresses the opinion of many physicians when he states "that such a condition should exist in a state which has heretofore had reason to be proud of its fine record in maternal health is indeed a tragedy." The action resulting from this suit should furnish some interesting legal argument.

A bill permitting the operation of clinics by hospitals or other health institutions, supervised by at least five licensed physicians, has been introduced into the present General Assembly and is now under consideration by the Committee on Public Health and Safety. A public hearing was held on April 10.

THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the \$37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

OBITUARIES

Richard Ambrose Outerson, M.D.

1878 - 1941

Doctor Richard A. Outerson died in St. Francis Hospital on February 5, 1941. He had been ill for eight weeks and died of cerebral thrombosis.

He was born in Windsor Locks in 1878, the son of Andrew and Mary Lawlor Outerson and attended the local schools and graduated from the Literary Institute of Suffield, Connecticut. From there he entered Jefferson Medical College where he graduated in 1902. He served his internship in St. Francis Hospital and was a member of that Staff for the past twenty years. He was President of the Interne Alumni Association of St. Francis at the time of his death.

Doctor Outerson was a member of The Hartford Medical Society, the Hartford County Medical Association, the Connecticut State Medical Society and the American Medical Association. He had served on numerous committees of the City and County Societies during the past fifteen years.

His outstanding characteristics were his good nature and friendliness. He was sixty-two years of age at the time of his death. We shall miss him greatly. Our sympathy goes out to his family.

Thomas F. Welch, M.D.

James Chapman Graves, M.D.

1875 - 1941

James Chapman Graves, Jr., was born in Marblehead, Massachusetts, December 26, 1875, and died at the Hartford Hospital January 26, 1941, of nephritis and uremia, having been ill for only a short time.

Doctor Graves received his A.B. degree from Amherst College in 1899 and his M.D. degree from Harvard Medical School in 1903. He interned at the Massachusetts General Hospital, 1904-5, and served as House Officer at the Corey Hill Hospital in 1906. In 1906 he accepted an appointment as surgeon in a lumber camp in Eureka, California. After a few months he entered general practice in Spokane, Washington. He married Eleanor Rand Goldthwait in 1911. Soon after he came East again to study orthopedic surgery under Doctor Noel Ernest Goldthwait, after which he again returned to Spokane,

Washington, and took up the practise of orthopedic surgery. In May, 1917, he entered the military service in the Royal Medical Corps of Great Britain. His first service was in Edinburgh, Scotland. Upon the entry of the United States into the conflict he was transferred as Captain in the United States Army Medical Corps and sent to the front lines before the arrival of the Rainbow Division. Later he was in charge of orthopedic work in a group of American Hospitals at Tours. During the debarkation of troops after the Armistice was signed he was on duty at Bordeaux, France. Returning to the United States early in 1918, he was stationed at Fort Snelling, Minnesota. He resigned from the service with a rank of Lieutenant Colonel and became associated with an Orthopedic Clinic at Tacoma, Washington. Eight months later he became associated in an Orthopedic Clinic with Doctors Prince and Fitch of Rochester, New York. In 1921 he assumed the position of Surgical Director of the Division of Industrial Surgery of the Medical Department of The Travelers Insurance Company.

With excellent cultural, religious and family background as well as years of general and specialized medical training and practice, Doctor Graves was exceptionally equipped to discharge the duties of this position. No one realized more fully the advantage of specialized medical treatment and guidance in industrial surgery for the shortening of suffering and disability with its attendant reduction of financial loss to claimant, industry and the insurance carrier. Conscientiously Doctor Graves followed this precept and was impervious to individual criticism since he knew his service was of broader scope.

Doctor Graves was a member of the Hartford Medical Society, Hartford County Medical Association, Connecticut State Medical Society, American Medical Association, American Orthopedic Society, Eastern States Orthopedic Association, Amherst Graduate Club of New York, Aesculapian Society of Boston, 20th Century Club, and he was Deacon of the Asylum Hill Congregational Church in Hartford.

Surviving Doctor Graves are his widow, Mrs. Eleanor Goldthwait Graves, and two daughters, Ruth Eleanor Graves and Mrs. Mary Graves Hammitt.

Friendly, affable, and courteous, Doctor Graves exemplified the principles of honor and gentility. He will be greatly missed by all who knew him.

Thomas H. Denne, M.D.

Thomas Francis Maher, M.D.
1878 - 1940

Thomas Francis Maher was born in New Haven, Connecticut, on May 10, 1878. He received his primary education in the Public Schools of New Haven and was graduated from Hillhouse High School in 1897. He received his M.D. degree from Yale in 1901. During the following year he served his internship at New Haven Hospital. During the period 1902 to 1908 he served as a Mining Surgeon for the South American Developing Company at Ecuadór, South America. For the following four years he was the mining surgeon for the Mazapil Copper Company at Mapami, Mexico. At the outbreak of the World War he was commissioned a First Lieutenant in the United States Medical Corps and was assigned to Fort Mead, later being transferred to Fort Travis, San Antonio, Texas. While there he assisted in the organization of Army Base Hospital No. 81. Later he was commissioned Captain and served as Executive Officer of Base Hospital No. 81 at Neufchateau, France. On his return from overseas service he was commissioned Surgeon in the Public Health Service and assigned to Providence, R. I., in charge of War Risk activities. On August 1, 1922, he was transferred to the United States Veterans Bureau, where he served as Chief Medical Officer. At the time of his death he held the commission of Major in the United States Medical Corps, Reserve.

Doctor Maher died on December 18, 1940, at the U. S. Veterans Hospital, Newington, Connecticut. He is survived by his widow, Helen Shanahan Maher.

At the time of his death he was a member of the following organizations: American Medical Association (Fellow); Hartford County Medical Association; Connecticut State Medical Society; Hartford Medical Society. He was Department Surgeon for the Veterans of Foreign Wars. He was also associated with the following: American Legion of R. I.; Providence Lodge of Elks; Chapter Bevarer No. 1, International Order of Exiles; Italian World War Veterans; Disabled Veterans of the World War; Military Order of the World War; Association of Military Surgeons. He was also an honorary member of the Yankee Division.

In the death of Doctor Maher the medical profession has lost a true and loyal friend. Among the

veterans' groups he always will be remembered as a true and loyal comrade.

Thomas R. Preston, M.D.

LETTERS TO THE EDITOR

Columbia, Conn.,

April 5, 1941.

S. B. Weld, M.D.,
54 Church St.,
Hartford, Conn.

Dear Sir:

The following item is an excerpt from a letter to the editor of Mead's Medical Sports Review from L. W. Bremerman, M.D., Los Angeles, Calif.:

"Bowling has developed to an amazing extent all over America. It is surprising how many medical men are taking to the sport. There has been developed many excellent teams in many of the states. It is the desire to organize an American Medical Bowling Association to participate in an annual tournament to be played at the convention city of the American Medical Association each year.

"We would like to have a team of five men from each state in the union to meet at Cleveland this year for the first tournament and for the purpose of the formation of a permanent organization to be known as the American Medical Bowling Association. Bowlers who may be interested kindly communicate with Doctor Lewis Wine Bremerman, 1709 West Eighth Street, Los Angeles, California."

Here's hoping that Connecticut will be well represented and that our team will capture the trophy and all other honors due them.

Sincerely yours,

T. A. LOUGHREY.

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54 Church Street, Hartford

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Cerevim is a pre-cooked cereal food of high nutrient values carefully balanced for the dietary requirements and digestive abilities of babies. It gets its calcium and phosphorus from milk powder and it is distinctly appetizing.

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All of which was indicated in 1937 in controlled studies on infants by Joslin and Helms¹ whose teachings are followed in the Cerevim formula.

Cerevim was designed to be *baby's* first solid food at 4 months, yet

—it has food values needed in the diets of adult invalids or dyspeptics requiring soft, bland, low-ash, easily digested diets attractive to frail appetites;

—Admiral Byrd bought it for 25% of the balanced trail ration for his husky men in the Antarctic. Council-accepted . . . Sold only through drug stores.

¹ARCH. PED., SEPT. 1937

Formula—Whole wheat meal · Oatmeal · Yellow corn meal
Barley · Powdered skim milk · Wheat germ · Dried
brewers' yeast · Malt · 1% table salt for flavoring.

PACKAGES: 1 pound and ½ pound.

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*Cerevim has been hitherto marketed on a three-year trial basis on the Atlantic seaboard by Cerevim Products Corporation with increasing encouragement from leading pediatricians; hereafter Cerevim will be made and sold by Lederle Laboratories, Inc.

These are your friends

QUARTO NOTES

MEDICINE AND HUMAN WELFARE. By Henry E. Sigerist, M.D., D.LITT., William H. Welch Professor of History of Medicine, Johns Hopkins University. *New Haven: Yale University Press.* 1941. 148 pp. 20 illustrations. \$2.50.

Reviewed by STANLEY B. WELD

Doctor Sigerist in this small volume has given to his readers a brief for a changing order in the practice of medicine, call it what you will—state medicine, federal medicine, or socialized medicine. The first third of the book is concerned with a resumé of disease, tracing the practice of medicine from early Babylonia to the present day. The second third discusses the problems of health, from the eras of Greek and Roman hygiene to the changes wrought in the concept of health by the advent of the Christian era. As an introduction to his claims for government medicine the history of the German health movement is outlined and reasons for its failure cited, viz., that "it was a movement of liberal middle class physician for the people but *without* the people."

In the final chapter Doctor Sigerist sketches the physician himself, the slave-physician of ancient Rome, the craftsman-physician of the Middle Ages, the scientist-physician of today. It is in this chapter that the author turns on the full force of his socialistic conception of the practice of medicine: "Every civilized country, including the United States, today undertakes a large and steadily increasing amount of state medicine and public medical services, financed through taxation, and it is these which are largely responsible for improved health conditions." Even though we may agree that "many health problems have been solved medically but remain socially untouched," yet all of us are not yet convinced that "there is only one way of achieving this (all medical care science can give for rich and poor), the physician must be removed from the sphere of competitive business".

Doctor Sigerist believes most of the present insurance systems of medical care are too conservative. He believes the general practitioner cannot exist without the support of a health center or hospital and a group of specialists. He believes we are all coming to group practice and that "medicine, like education, will ultimately become a public service in every civilized country." A new physician certainly is gathering form on the horizon but one must be a prophet like Doctor Sigerist to visualize more than the vaguest outline.

DOCTORS AND DOCTORS WISE AND OTHERWISE.

By Charles McDaniel Rosser, M.D. Dallas: Mathis Van Nort & Co. 1940. 400 pp. illustrated. \$3.50.

Reviewed by J. C. ROWLEY

Immediately after the Civil War when Doctor Rosser was a small boy his parents emigrated from Virginia to Texas where he helped clear the land, taught school, "read medicine" under the local doctors and thus worked his way through the Medical Department of the University of Louisville, finally taking up the practice of medicine in Dallas.

His autobiography is the story of an able, ambitious and

Good Treatment for Your Taste

If your taste responds to smooth mellowness, Johnnie Walker is indicated.



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A complete technique of treatment and literature will be sent upon request

*Silver Picrate is a definite crystalline compound of silver and picric acid. It is available in the form of crystals and soluble trituration for the preparation of solutions, suppositories, water-soluble jelly, and powder for vaginal insufflation.

Silver Picrate, Wyeth, has a convincing record of effectiveness as a local treatment for acute anterior urethritis caused by *Neisseria gonorrhoeae*.¹ An aqueous solution (0.5 percent) of silver picrate or water-soluble jelly (0.5 percent) are employed in the treatment.

1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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energetic surgeon from pioneer days until 1935. He was active in the State Medical Society and in founding the first Medical College in Dallas, later to become Baylor University College of Medicine where he was professor of surgery for many years. The book will be of interest to those concerned with medical history and legislation in Texas.

A MANUAL OF THE COMMON CONTAGIOUS DISEASES. (Third edition.) By Philip Moen Stimson, A.B., M.D., Assistant Professor of Clinical Pediatrics, Cornell; Visiting Physician, Willard Parker Hospital, New York. Philadelphia: Lea & Febiger. 1940. 465 pp. illustrated. \$4.00.

Reviewed by J. C. ROWLEY

A large part of this book has been rewritten and much new material has been added but without unduly increasing the size of the book. The descriptions of the etiology of scarlet fever and measles, the prophylaxis and specific treatment of whooping cough and of meningococcus meningitis, the prophylaxis of poliomyelitis and the use of sulfanilamide and sulfapyridine are largely new. Four excellent colored plates showing different rashes and throat and mouth lesions are also new.

At the end of each chapter is a complete bibliography.

Each disease is adequately covered and the material is thoroughly up to date.

The book is well written, is clear and concise and contains all essential details.

Doctor Joseph Strong

The Biography of Doctor Joseph Strong 1770-1812 Philadelphia Physician by Lockwood Barr was published in *The Yale Journal of Biology and Medicine*, March 1941. Joseph Strong was born at South Coventry, Connecticut, and was graduated from Yale College so that his life is of particular interest to Connecticut physicians. Nathan Hale was his cousin.

Lockwood Barr's account is interesting as it includes the story of the axle tourniquet invented by Joseph Strong and advertised in the Connecticut Courant issue of March 16, 1801.

Industrial Health Number

Again Indiana leads, this time with an Industrial Health number of the *Journal of the Indiana State Medical Association*. This appeared in April, 1941, and contains some very excellent articles on different phases of industrial medicine. Congratulations to Editor Shanklin!

Table of Contents : June 1941

ORIGINAL PAPERS

WEATHER AND THE PRACTICE OF MEDICINE	William F. Petersen, M.D., Chicago	405
SOME EARLY MEDICAL TEACHERS IN CONNECTICUT	H. B. Ferris, M.D., New Haven	411
GASTRO-INTESTINAL DISTURBANCES IN NERVOUS AND MENTAL DISEASE	Benjamin V. White, M.D., Hartford	425
NEUROLOGIC LESIONS THAT GIVE GASTRIC SYMPTOMS	James C. Fox, Jr., M.D., New Haven	429
PSYCHIATRIC CONSIDERATIONS IN SELECTION OF MILITARY PERSONNEL	Louis H. Cohen, M.D., Norwich	453
EVALUATION STUDIES OF LABORATORIES PERFORMING SERODIAGNOSTIC TESTS FOR SYPHILIS	Friend Lee Mickle, sc.d. and Earle K. Borman, M.S., Hartford	434

CASE REPORT

HYPERNEPHROMA WITH METASTASES TO SCAPULA	L. L. Tylec, M.D., Waterbury	432
--	------------------------------	-----

EDITORIAL

Were You There?	440	The Foreign Graduate	441
A Real Honor	440	Commendation Appreciated	441

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	442	OUR NEIGHBORS	469
CONNECTICUT HOSPITAL ASSOCIATION	445	THE FORUM	472
MEDICAL PREPAREDNESS	450	NEWS FROM COUNTY ASSOCIATIONS	473
THE LEGISLATURE	458	QUARTO NOTES (Book Reviews)	478
INDUSTRIAL HEALTH	461		

MISCELLANEOUS

MESSAGE FROM THE PRESIDENT	439	SPECIAL NOTICES	470
OBITUARY	469	OFFICERS AND COMMITTEE CHAIRMEN	
		Connecticut State Medical Society	4
ANNUAL REPORTS	465	Connecticut Hospital Association	4

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The CONNECTICUT STATE MEDICAL JOURNAL

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JUNE, 1941

No. 6

WEATHER AND THE PRACTICE OF MEDICINE

WILLIAM F. PETERSEN, M.D., *Chicago*

The Author, M.D., *Rush Medical College, 1912. Professor of Pathology, University of Illinois, 1919 to date*

THE SUDDEN DEATH OF CALVIN COOLIDGE

ON JANUARY 5, 1933, a well known New England citizen named Calvin Coolidge was found dead in bed. Apart from a minor complaint of hyperacidity, he had been apparently quite well. Death was ascribed to "heart disease," presumably coronary thrombosis.

Calvin Coolidge, a taciturn, shut-in, so-called "typical" New England Yankee, had for many years suffered from hay fever and from asthma. So sensitive was he to change in autonomic balance that merely going aboard a ship would make him sea sick. He had a "delicate stomach," i.e. either functional over- or under-activity, with hyperacidity as an old complaint.

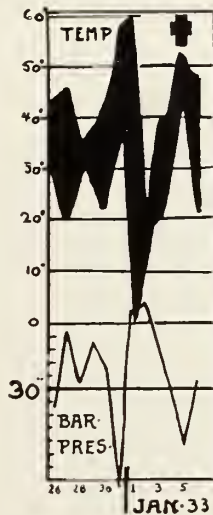
This clinical picture is commonplace enough, and Jarvis of Vermont has clearly developed the symptoms that present themselves to the observing practitioner in his "plus" and "minus" types of persons.¹

What killed Calvin Coolidge? In the final analysis, the weather.

On December 31, 1932, temperatures in New England had been in the 60's. Then, on the 1st of January there followed a drop of 50° F. in 24 hours! Adjustment to such an environmental blow taxes the energy stores of the best of men. There followed an equally rapid rise in temperature, so that by the 5th of January temperatures again were in the 50's. The small meteorogram illustrates the situation. At the temperature crest Calvin Coolidge was found dead. (Text Figure #1.)

ABRAHAM LINCOLN BROKE HIS ENGAGEMENT

On January 1, 1841, just about one hundred years ago, a very tall and ungainly young State Representative, living in an embryonic mid-western capi-



TEXT FIGURE #1
Meteorogram for the Period when Calvin Coolidge Died. Note the sharp fall in environmental temperatures with an equally rapid rise to January 5, 1933, the day of death.

tal, was emotionally upset. His name was Abraham Lincoln and on that day he broke his engagement to Mary Todd. For several days thereafter he was still disturbed, then returned to the routine of the legislative session. Suddenly, two weeks later, a profound depression set in with incoherent and rambling talk, threats of suicide, and complete withdrawal. Later, in a long letter to Doctor Daniel Drake he recited all his symptoms.

Such symptoms are common enough, especially in the unstable and unusual individual. When exaggerated, periods of mental turmoil of this nature form the background of the acute psychotic episodes in the insane.

What brought this peculiar emotional battle of the sexes into focus? What interrupted the normal course of recovery after the first violent storm? What precipitated the second attack?

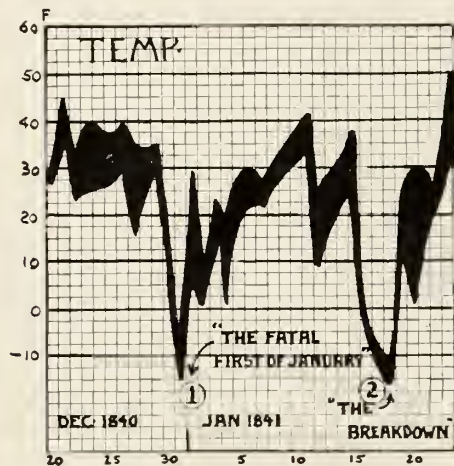
In the final analysis, a brusque change in the physical environment, namely, the weather.

On December 29, 1840, environmental temperatures in Illinois were well above freezing; on the 30th, a cold wave began to pass; by the 31st, 10°

From the Department of Pathology, Bacteriology and Public Health, University of Illinois, College of Medicine, Chicago.

below zero was reported by the observer at the Army Post at Warsaw, Illinois (now Rock Island). By the 5th of January, temperatures were again above freezing.

Then came another cold wave. On the 13th of the month it began to snow; on the 17th, temperatures began to fall abruptly; by the 19th, barometric pressure was at its crest and temperatures were down to the zero level. (Text Figure #2.)



TEXT FIGURE #2

Meteorogram to Illustrate the Lincoln Episodes. In the graph only the maximum morning and evening temperatures are recorded. Note striking decline in environmental temperatures (1) when Lincoln made the decision to break his engagement, i. e. the fatal 1st of January, and (2) when Lincoln became disturbed and threatened suicide.

A THYROTOXIC AND DIABETIC CRISIS

On December 5, 1924, a Jewish housewife, 29 years of age, entered the Deaconess Hospital in Boston (service of Doctor Root²) with a history that she had developed polyuria and polydipsia about the 1st of November, 1924.

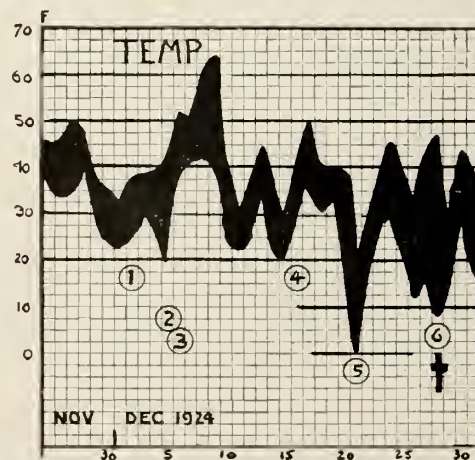
On December 2 (1) she commenced to vomit violently and entered the hospital at ten in the evening of December 5 (2), at which time a diagnosis of hyperthyroidism was made. On the morning of the 6th (3) she became drowsy and unconscious (diabetic acidosis).

On December 16 a septic temperature began (4). Jaundice followed on the 21st (5) and death on the 28th of December (6). The pathological findings included a fatty myocardium, multiple infarcts and abscesses of the lungs, a secondary bronchopneumonia, etc.

There is nothing unusual in such a story. In New England both thyroid and diabetic crisis, combined or separate, occur with frequency. But why the sudden precipitation of the disease? What makes acute a latent dysfunction or autonomic dysintegration?

In the final analysis, any environmental factor that increases the energy load which the organism must carry. Any energy impact—traumatic, emotional, infectious, toxic—must be a primary or conditioning factor in a series of events, and actually weather changes are most often directly responsible.

On November 27 Boston temperatures were still in the forties. When the patient became ill (1) and was hospitalized (2), a cold wave was passing. Improvement followed with treatment and with warmer weather. Then came another major change from the high temperatures of the sixties to a low of 20° F. and with it (4), the patient's temperature began to rise. With an accentuation of cold (5) jaundice followed, and death came with a later fall in temperature (6). (Text Figure #3.)



TEXT FIGURE #3

Meteorogram to Illustrate the Clinical Episodes in Doctor Root's Patient with Thyrotoxic and Diabetic Crises. (1) Beginning of vomiting, (2) and (3) hospital admission and coma, (4) beginning of septic temperatures, (5) icterus, (6) death.

These episodes have been selected because of their dramatic interest, but in varying measures of intensity, in an endless variety of clinical expression, and in absolute dissimilarity of outcome, phenomena of this sort are always passing under our observation.

Because weather change is such an every day affair, possibly because of our preoccupation with detail or because of our interest in the particularistic

rather than in the general phenomena of disease, we have in the last half-century quite ignored this major factor, namely the weather, in the precipitation of that disharmony of organic rhythm which becomes manifest as clinical disease. It makes no difference what the cause of the disease (endocrine, infectious, traumatic, congenital, deficiency), greater energy demand associated with change in the weather is very apt to bring the clinical picture into focus.

We experience a state of health and well being as long as our complicated organic mechanisms manage to maintain a dynamic equilibrium. All organic functions are constantly undergoing a rhythmic pendulation, because we must maintain our balance in the face of innumerable energy impacts which reach us by the skin and mucous membranes, gastrointestinal tract, the lungs, or special sense organs, or which may have an endogenous source, possibly of emotional origin, endocrine rhythm, etc. No simple reaction of any organic balance can occur without involving practically all other balances.

I shall illustrate this pendulation and the restoration of the normal equilibrium after a single energy impact by a curve (the observations are those of my colleague, Doctor Nedzel) of the blood pressure in a normal dog following a single injection of pitressin. This is here used by way of illustrating disturbance of the autonomic equilibrium such as that which might be induced by cold, an emotional disturbance, etc. (Text Figure #4.)

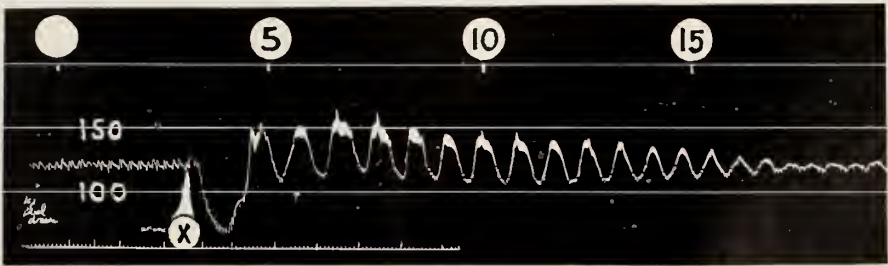
It will be observed that after the injection (X) there is an increase in blood pressure; then follows a profound decline (due to an effect of the pitressin on the coronary circulation). Then waves of increasing and decreasing amplitude appear in the blood pressure curve, quite analogous to those that

can be observed if we merely throw a stone into the quiet waters of a pool. The pendulation continues until an equilibrium is finally reached. If we now visualize related and integrated rhythms of this sort constituting the reaction to the innumerable energy impacts that impinge on the human organism we will begin to understand the character of the changes that occur when environmental demands such as those initiated by weather change are made on the organism.

It is not possible in the space limitations of a paper of this kind to discuss important meteorological questions that are concerned for the type of atmosphere in which we exist. In the northern part of the United States we live in a region of major cyclonic air mass disturbance where cold (polar) air masses alternate with warmer (tropical) air masses, the so-called cyclone.*

To illustrate the basic mechanisms involved in the human reaction to weather change we can make use of a blood pressure diagram (Text Figure #5). In the first of the figures the systolic blood pressure level is indicated to rise from approximately 110 to 120 in the course of two days and to decline to a level somewhat lower than before. This is a characteristic reaction to any environmental impact such as cold, emotion, exertion, infection, trauma, etc. With the passage of a cold air mass (i.e. a drop in environmental temperature or an equivalent effect, such as that due to a change in the moisture content of the air, in the wind velocity, in lessening

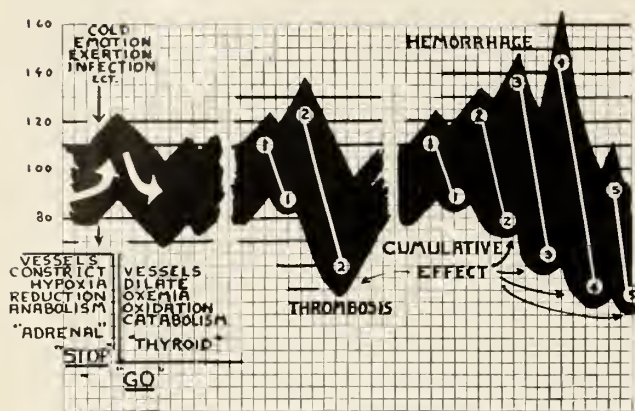
*The meteorological use of the term cyclonic or tropical air mass, it should be understood that we are not dealing with the so-called prairie twister, that the term indicates the great light air masses, that rotate counter clockwise and have a considerable speed as they pass usually from the northwest across the continent and exit over the New England region.



TEXT FIGURE #4

Characteristic Blood Pressure Curve Following Pitressin Injection in Dog. Experiment of Doctor Nedzel. Injection at (X). Time in minutes indicated by the upper circles. Note the initiation of waves

of increasing and decreasing amplitude until equilibrium is restored. Every energy impact brings about similar biochemical pendulation in varying degrees.



TEXT FIGURE #5

Diagrammatic Presentation of Phase Pendulation as Evident in Blood Pressure Levels with Energy Impacts such as Cold, Trauma, Emotional Disturbance, etc. The first diagram illustrates a simple episode, the second and third summation events. At the crest of blood pressure hemorrhage may occur, at the maximum decline thrombosis, infection, etc.

of radiant heat, etc.), the human body, being hairless, proceeds to a normal effort to insulate itself. The peripheral tissues, particularly the skin and the mucous membranes respond with a constriction of their vascular bed, so that there will be less radiation of heat. During this stage anabolism dominates the metabolic state, the organism, as it were, gets the "stop" signal and cells in general are less permeable and offer greater resistance. The blood pressure under these conditions reveals a tendency to increase, blood sugar increases because of greater release from the liver and lessened use in the peripheral regions, the venous blood becomes more alkaline, etc.

This phase, because of a relative closing of a large part of the vascular bed, is associated with a relative anoxia. This anoxia in turn results in the production of more capillary active substances such as CO_2 , intermediary acid products from the improper combustion of fats, histamine-like substances,³ etc. With the liberation of such substances a reactive phase follows in the organism and the original trend is reversed, the blood pressures now fall, metabolism increases, the venous blood becomes more acid, etc.

If we now assume a double impact such as that which would be imposed with the rapid passage of two cold air masses in sequence, or a single cold air mass associated with trauma, or if we assume a series of impacts such as illustrated in the third portion of the graph, the organism may reveal blood pressure

extremes, either high or low, and at the crests or troughs we might anticipate the precipitation of clinical events. In simplest expression we might expect arterial hemorrhage at crests or thrombosis and venous hemorrhages with periods of unusually low blood pressures; we might find a change in mood, elation occurring with periods of higher blood pressure; and depression after diastolic lows.

If organs are operating in the marginal zone of oxygen and nutritive adequacy, such wide excursions of the blood pressure mechanism may bring the defect into the foreground. If tissue areas exist that are out of step, that is, if areas of real pathology exist, they, too, will register distress when the ion balance, or the oxygen balance, or the water balance can no longer keep pace with the changes that have occurred in the organism as a whole as a result of the necessity to adjust to weather change. Then we may observe "growing pains" in the young and rheumatic pains in the old, headache or neuritis or paralysis; urticaria and asthma and colitis. Then the diabetic acidosis is precipitated or the myocardium becomes defective or the patient develops a uraemic coma. Or we find reflections in the mental sphere: a change in mood, hyperactivity, depression, the onset of an acute psychosis, a catatonic episode.

In the case of Mr. Coolidge the following series of reactions occurred. The abrupt cold wave of December 31 was followed by a marked vasoconstriction with high blood pressure levels, with the release of sugar, with a transient alkalosis. This, in the normal course of events, was followed by unusual stimulation because of the anoxia of the preceding phase. Capillary-active substances were formed in large amounts, the stomach mucous membranes reacted with a hyperacidity (Mr. Coolidge took bicarbonate), the blood pressure fell, the blood vessels became more adhesive, and the coagulation time was lowered. At this time a sudden warm wave followed—temperatures rose abruptly. His blood pressure fell still farther than before, the coagulation time became shorter and shorter. During the night (diurnal cycle!) this state was again accentuated and clotting occurred in the coronary vessels.

In the case of Mr. Lincoln, it was the change in mood that reflected the change in weather. The passing of the cold air mass resulted in a transient, though possibly sharp, increase in his blood pressure, and then came the reaction. His blood pressure reached a low level, the feeling of inadequacy, "depression," was paramount, and he resolved to break

the engagement. With the repetition of the weather situation two weeks later came the repetition of the depression, the feeling of total inadequacy, and the threat of suicide.

In the thyroid-diabetic case of Doctor Root which was used for illustration, the first cold wave placed greater strain on the thyroid-adrenal mechanism. The defective organism could not adjust to the unusual demand. First the blood pressure would increase (a typical sympathicotonic effect), blood sugar would be liberated from the liver, but less sugar could be handled by the tissues because the great peripheral bed was less active. Oxidation being impaired, more and more capillary-active (histamine-like) substances would be rapidly formed, an acidosis would become evident, with vomiting and coma.

Then came readjustment. But now the next cold wave followed (4) with its infection; with the succeeding cold wave (5) trouble became apparent as liver damage; death followed with the next blow (6).

INFECTION

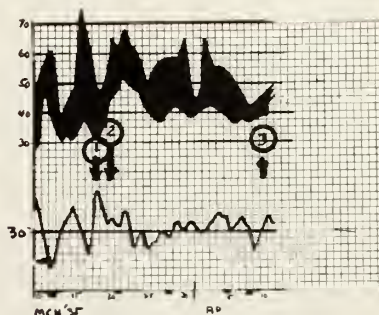
Weather change, finding reflection in the organic phase of the patient, prepares the way for the penetration of infecting organisms. With the weather, the respiratory mucous membranes change their status (pH pendulation, change in lysozyme, in the hydration, in the number of leucocytes, etc.) and in the "go" phase, i.e. with fall in blood pressure, etc., bacterial penetration is enhanced. I merely turn to a characteristic record (Mendell, Meranze and Meranze) of another diabetic patient:

It concerns a white female, 59 years of age, who was admitted on March 20, 1935 (2), critically ill in a state of diabetic coma with massive infection and spreading necrosis of deep tissues of the upper half of the right thigh. She had been drowsy for 48 hours (1) at home as the infection was progressing, then lapsed into coma prior to admission. Despite energetic treatment the infection could not be checked, she became more septic, and expired on April 10, 1935 (3).

When we examine the meteorogram (Text Figure #6) for the time concerned in Philadelphia, we observe that the patient became seriously ill (1) with a barometric crest, after an unusually sharp fall in temperature from a high of over 50° F. Admission to the hospital followed immediately in the wake of this episode (2). Finally death occurred with a baro-

metric crest and again after a period of falling temperatures evident in the meteorogram (3).

Atmospheric change, though a commonplace in our every-day lives, is actually the dominant force to which physiological adjustment must be made by the human; cold and cooling effects are still the major energy impacts of the environment. Brusque alterations most often initiate clinical episodes. But minor changes, repeated in rapid sequence or at critical intervals, are possibly of equal significance in the initiation of dysfunction and finally of anatomically observable pathological changes. Of course the individual resistance varies; it depends on the physical type, on the sex, the age, on the degree of protection or exposure, on the genotype, on previous experience. So, too, each region offers its own peculiarities. High altitudes may lessen the effect of cold, the ocean coast will moderate temperature fluctuations, the amount of iodine in the soil or the availability of direct sunshine, the shelter of the mountain range against wind, the change in air ionization in industrial centers—all these and many more factors must be considered.



TEXT FIGURE #6

Meteorogram to Illustrate the Clinical Events in the Case of Doctors Mendell, Meranze and Meranze. (1) and (2) Onset of illness and admission to the hospital. (3) Death of the patient.

Obviously the interrelation of the most variable of climates, as that in New England, and the most differentiated of human groups* offers situations that are by no means always as simple as those used for illustration, but the Hippocratic introduction to medicine is still valid:

"Who ever wishes to pursue properly the science of medicine must proceed thus. First he ought to

*Detailed discussion of the mechanisms involved and their relation to a wide variety of clinical phenomena in the human will be found in a series of monographs ("The Patient and the Weather"—Volumes 1 to 4, 1934-1938.)

consider what effects each season of the year can produce; for the seasons are not at all alike, but differ widely both in themselves and at their changes. The next point is the hot winds and the cold, especially those that are universal, but also those that are peculiar to each particular region."

"If it be thought that all this belongs to meteorology, he will find out, on second thoughts that the contribution of astronomy (i.e. the calendar) to medicine is not a very small one but a very great one indeed. For with the seasons men's diseases, like their digestive organs suffer change."

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Old Age

When is a man old?

Elbert Hubbard once remarked "The good die young—no matter how long they live."

Upon mature consideration we feel that the word, "good," in this aphorism, might be replaced by "active," "progressive," "enthusiastic," or any other word which would indicate that a man is keeping up a vital interest in life, changing as times change and *growing* all the while.

When should a physician—or any other man—retire?

As soon as he loses interest in and enthusiasm for his work or feels that he knows all there is to know about it.

We all know that the number of years a man has lived is no adequate index of his age. There are some

who are antediluvian mummies at thirty, and others who are vital factors in the life of their communities at ninety. So long as a man is doing something worth while and means something to the world, he is young.

If you have lost interest in medical society meetings; if you "cannot find time" to read one or two medical journals (at least); if the last book in your library is ten years old, or the later ones haven't been *studied*; if "what you learned in medical college is good enough" for you; if "all these new-fangled notions are damned foolishness," you are growing old, as a doctor.

Don't let life bury you until you are dead. Keep living and learning and loving and you will stay young.

Jour. Fla. Med. Assoc., April, 1941.

Prosperity at Home

Connecticut wages top the average in the country as disclosed in an analysis of 1939 census data on labor and production in the United States. Taking figures just released by E. F. Bemis of the Bureau of Foreign and Domestic Commerce, it is found that the average annual wage in 1939 for the reported 233,525 wage earners in Connecticut, receiving a total payroll of \$276,274,243, was \$1,187, against the national average of \$1,152 and the average for New England of \$1,077.

Comm. Industry, April 1941.

The Beaumont Bridge

The House of Delegates of the Michigan State Medical Society passed a resolution in September, 1940, petitioning the proper authorities that the bridge being built between the two peninsulas of Michigan be called The Beaumont Bridge.

Michigan is getting the jump on Connecticut in doing honor to a renowned surgeon who was a native of Connecticut.

PROFESSIONAL HEADACHES:—Few medical men can run an office without having an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co., New Haven.

SOME EARLY MEDICAL TEACHERS IN CONNECTICUT

H. B. FERRIS, M.D., *New Haven*

IN ORDER TO appreciate the conditions and difficulties which surrounded the early medical teachers in Connecticut, it will be necessary to give a brief resumé of the general educational and social conditions of Colonial times and also of the status of medicine. The population of Connecticut in the early part of the 18th century was probably well under 200,000 and that of Middlesex County about 19,000, while New Haven, one of the two largest places contained less than 3,000 people. The population was much more diffuse than at present and the country village relatively much more important and influential. Nearly everyone, even professional men, were more or less agriculturalists, and the majority of families largely provided themselves with food and clothing. It was not until near the end of the 18th century that the factory system began to develop, resulting in the great and deplorable concentrations in the cities which exist today.

There were many stretches of wilderness still inhabited by the Indians whose superstitions and medicaments were not without influence on the people and physicians of Colonial times.

Transportation during the seventeenth and eighteenth centuries was largely by horseback over trails or poor roads, except for the river and shore towns which in addition enjoyed the advantage of marine transportation. Communication by mail or messenger was slow, and subject to delays even for the towns along the main roads. Modern conveniences of running water, generally heated houses and general illumination were unknown. The well sweep furnished the water, one or two rooms only were imperfectly heated by fireplaces. Anyone who has occupied an unheated bedroom in a country house in the winter will appreciate the discomforts the people endured. The warming pan and foot stove were not mere ornaments in those times. Imagine the discomforts patients and attendants must have suffered under such conditions and also the difficulties involved in literary pursuits. Wages were low as indicated by this item in Doctor Gershom Bulkley's account book 1681, "for one day's work daubing the house, 2 shillings." Food was likewise low in price as shown by the following items, "Butter, 6 pence per pound, side of pork at 3 pence per pound."

Educational facilities were very meager consisting of scattered and poorly equipped country schools with here and there an academy in the larger villages. Books were scarce and expensive, instruments and apparatus must be imported from Europe. Harvard College, founded in 1638, alone presented opportunities for higher education in the colonies during the 17th century. While no professional schools existed during most of the 18th century, some of the colleges gave a few courses pertaining to theology, law and medicine. The first medical school founded was the Medical School of the College of Philadelphia, now the University of Pennsylvania, in 1765.

This paper by the late Doctor Ferris was read before The Beaumont Medical Club October 11, 1921. It is here reprinted by permission of the publishers of the BULLETIN of the Society of Medical History of Chicago.

The 19th century, however, witnessed an extraordinary accession of medical schools, largely proprietary, until the number in the United States a few years ago reached 185. This number is now reduced to about 85.

During the 17th and 18th centuries there was a great scarcity of medical books while medical journals were entirely lacking until 1797 when a quarterly, *The Medical Repository* started publication in New York. Before this, however, about 1790, there had been published in New York translations from the *Journal de Medicine Militaire*. It is of interest to us that this first medical journal had its origin in Connecticut and that it was edited by a Connecticut man and Yale graduate, Doctor L. S. Mitchell.

Not only were the Colonial physicians hampered by the lack of journals and books but also by the lack of organization. The first medical society to be established in the United States was the New Jersey State Medical Society founded in 1766. The first medical society in Connecticut was the Litchfield County Society founded in 1767, while it was not till 1792 that the medical forces of the state were organized as the Connecticut Medical Society.

Physicians also were obliged to rely largely on medical books published abroad. In 1776 there was only one medical book, chiefly a compilation, three reprints and about twenty pamphlets by American authors. The title of this book has at least whatever merit there may be in alliteration. It was "Plain, Precise, Practical Remarks on the Treatment of Wounds and Fractures," by Doctor John Jones, N. Y. 1775.

The only public medical library, even as late as the latter part of the 18th century, was that of the Pennsylvania Hospital, containing about 250 volumes. At this time there were not 200 graduates in medicine in the country and not over 350 practitioners who had received a liberal education. In Connecticut there were scarcely 200 practitioners, most of whom were very poorly trained. It is greatly to the honor of Connecticut and New Haven that perhaps the first original work published in the Colonies was "Cases and Observations by the Medical Society of New Haven County in the State of Connecticut" published in 1788. This contained twenty-eight articles, including the relation of several cases and the description of some autopsies. This publication received very favorable mention both at home and abroad and greatly aided in obtaining a charter for the State Society which earlier had been refused.

The first record of dissections of the human body for teaching purposes seems to have been about 1755 when the body of Hermanus Carroll, a criminal, who had been executed for murder was dissected in New York by Doctor John Bard and Doctor Peter Middleton, two of the most eminent physicians of the day. During the years 1754 to 1756 a course of lectures on anatomy and surgery was given at Newport, R. I., by Doctor William Hunter, a Scotchman, trained at Edinburgh under the first Munro, and a relative of William and John Hunter. Not only medical students and physicians were invited to these lectures, but all the literary gentlemen of the town.

In view of all these facts it is not strange that charlatantry, ignorance and incompetence were rampant. "Even as late as 1792" says Doctor Thomas Miner in his presidential address to the Connecticut Medical Society in 1834,

"there was scarcely one competent practitioner to a county." In New York the General Assembly in 1760 ordained that no person should practice in New York City as a physician or surgeon before he had passed an examination and prescribed a penalty of 5 pounds for violation of this law. Connecticut, however, imposed no restrictions on practice until 1891; although in early times to obtain a license it was necessary to pass an examination.

When the first medical school was started in 1765 at Philadelphia all students who did not have a college degree were required to pass an examination for entrance. These requirements later became very loosely administered by all the schools until some proprietary schools would accept almost anyone who could read English. Two degrees were given. For Bachelor of Medicine one must serve an apprenticeship, have a general knowledge of pharmacy and attend one complete course of lectures and follow the practice of a general hospital for one year. To obtain the degree of M.D. the candidate must have been a Bachelor of Medicine for three years, be 24 years old and write and defend a thesis.

Even as late as the end of the 18th century chemistry was still in its infancy; Lavoissier's work was not published until 1773. Physics as we at present know it, was hardly dreamed of; anatomy limited to coarse descriptions; microscopic anatomy practically unknown; pathology consisted chiefly of crude speculations, while obstetrics was conducted entirely by midwives except in difficult cases when physicians were called in. It was only in 1756 that obstetrics was introduced among the studies at Edinburgh University and was even then an appendage of anatomy and taught by that chair until 1810. Specialism apart from general practice did not exist. Medicine was largely theory with little basis of observed fact. Diagnosis was crude and surgery had not experienced the blessings of anaesthesia and asepsis.

The profession was recruited from several sources. There were first those who were "natural healers and bone setters" and felt that they were competent without training. Some of these were women. Secondly there was a group who by association in various ways with physicians and the sick had "picked up" some knowledge of remedies, who perhaps by "riding" with a physician for a few months were able to "ride alone." Others served an apprenticeship of one to several years with a reputable physician and became reasonably trained for the times. These medical apprentices performed a variety of services many of which did not pertain to medicine. Besides collecting herbs and roots, preparing decoctions and electuaries and making pills they mended the saddles, curried the horses, cleaned the stables, and even weeded the garden. In many instances they were very rigorously treated and kept intensively at menial tasks. At the termination of his apprenticeship the student received a certificate. The following is a sample:

This may certify whom it may concern that I ye subscriber for two years time have given Thomas Thompson at Farmington sundry in ye mysteries of physics and Chirurgery and doe find that ye said Thompson hath made a consideral progress in said arts and withal finding him to be very careful in his practice and administrations—doe judge to be a man as likely to do good in said mysteries as any man I know of that is not advantaged with college learning.

Farmington, March ye 29, 1704.
Thomas Hastings licensed
Physician, etc.

Another certificate of a later period follows, given by Doctor John Noyes of Lyme to Richard Ely of North Madison, who graduated from Yale in 1765.

To all people whom these lines shall coome Greeting:

Whereas Dr. Richard Ely of Saybrook, hath been liberally educated and been a student with me in the theory and practice of medicine and surgery, and whereas said Ely hath made great improvement in the art of physics and surgery, he is well qualified for a practitioner in said arts. I do therefore recommend him as a safe, judicious and able physician, and well qualified to practice.

Lyme, June 9, 1786,
John Noyes.

It is interesting to note that this certificate was not given until twenty-one years after Doctor Ely graduated from Yale and when he must have been about 40 years of age.

Another small group either "walked the hospitals" abroad or took a degree generally in Glasgow, Edinburgh or Leyden.

No records were found indicating the nature of the financial arrangement that existed between the medical apprentice and his preceptor, nor whether the student had opportunity to dissect or to see dissections of the human body or to witness autopsies or even often to study a skeleton. The basic sciences of medicine, anatomy, physiology, chemistry and pathology must have been learned almost entirely from books. Not so the clinical side, for the intimate relation of patient, student and teacher was in some respects nearly ideal.

The original copy of the following advertisement was kindly loaned me by Doctor Harold Arnold.

Information is hereby given, that the Subscriber completed his Professional Education, in the City of Philadelphia; by hearing Lectures on the various branches of the Profession; and by attending at the same time, their several Institutions, for the benefit of the sick; and that he has been in the habit of giving Lectures to Students of Medicine for eleven years past, in imitation of his Professors, so far as in his power, viz.—Lectures on* Anatomy, and Physiology, Theory and Practice of Physics, Surgery, Materia Medica, Natural Philosophy, Chemistry and Botany.

When Students have not previously attended to the Greek and Latin language sufficient to understand the Medical Writers (that being necessary, agreeable to a By Law of the Connecticut Medical Society), or, if they are unacquainted with the grammatical construction of the English language, they are attended to.

Students on an average, are entitled to one hour's attention daily, in hearing lectures on the above subjects, and in asking and being asked questions; when business prevents attending to them on one day, they have the time made good to them on another.

It has frequently been the case, that students engaged in the study of the Profession, have come and attended Lectures on part of the foregoing branches, and then return to their former Professors, to complete their studies and be licensed to practice; should this be an accommodation to any Students in future, it will be a matter of attention, when desired.

Those Gentlemen, who are disposed to attend Lectures on the above subjects are hereby invited to call and satisfy themselves more particularly.

WILLIAM B. HALL.

Middletown (Conn.), July 14, 1802.

*The subscriber has a Skeleton he prepared while in Philadelphia, which must be of great use to the Student, in acquiring a knowledge of the anatomical structure of the human body.

From a consideration of the above facts, the lack of general educational facilities which breed superstition, and the lack of good medical teachers

and medical schools, we can realize the unique service which the clerical physicians of early times performed for the Colonies as practitioners of medicine but especially as medical teachers. Here at least were men mentally well trained, men of power and versatility who in many instances served as magistrates, political leaders and clergymen, as well as physicians and medical teachers.

Further, as there were no drug stores, physicians were compelled to largely compound their own medicines and it was not until near the end of the 18th century that the physicians made way for the apothecary. This movement of separation was started by Doctor Norman Morrison of Hartford and later as a result especially of the influence of Doctor Morgan of Philadelphia it became an accomplished fact.

Treatment by bleeding does not seem to have been resorted to very frequently in the 17th century. It was not until the 18th century that Sangrado became so popular and it became the fashion to be bled every spring as a prophylactic as well as in most diseases. "Shot-gun" prescriptions and weird combinations of drugs were commonly given. The usual charge for a visit was a shilling but the high prices charged for medicines are astonishing. The visit of the doctor was not only professional but a social matter as well, and as ardent spirits were in ordinary use the physician who took a "refresher" as was expected before seeing each patient, was likely to become somewhat overwrought by night. Office hours were unknown, the doctor starting off in the early morning dined at whatever patient's house he happened to be at dinner time. It is reported of one physician that whenever he entered a house at meal time he first entered the kitchen and lifted the cover from the kettle. If the contents did not appeal to him he went further for dinner.

It is probable that every physician of repute had one or more students as apprentices but some attracted many students. Those teachers who became distinguished and drew the best students were generally men who either had received degrees abroad before coming to this country or were clerical physicians.

The earliest record we have of any physician in New England is of Doctor Samuel Fuller who came to Plymouth in the Mayflower in 1620. We do not know whether or not he trained any students. The first medical teacher that we have record of is the Rev. Giles Firmin of Ipswich, Mass., who had received a good medical education in England before coming to this country. He gave lectures in anatomy in Cambridge, using a skeleton for demonstrations. But lecturing on anatomy proved as poor a business then as now and he was soon forced by poverty to return to England as a clergyman.

John Winthrop, Jr., the governor of Connecticut, also practiced and probably trained students. His favorite remedy was rubila, the composition of which was secret. It is said to have been a combination of 4 grs. of (diaphoretic) antimony with twenty grains of nitre and a little salt of tin with some coloring agent.

Thomas Pell was the first recorded practitioner in Connecticut, although probably the Rev. Thomas Hooker had medical knowledge and practiced.

Doctor Pell was surgeon at the fort at Saybrook and "Chirurgion" in the expedition against the Pequots in May 1637. He came to New Haven about 1642 and both practiced and engaged in commercial pursuits. Here he seems to have had much trouble and many lawsuits. He purchased in 1663 a large tract of land between Westchester and the Hudson River, a part of which later became known as Pelham Manor. He died in Fairfield, September, 1669. According to the inventory of his estate his library was very small and Culpepper's Dispensary seemed to be the only medical book that he owned.

Thomas Lord of Hartford was the first physician licensed by the General Court, June 30, 1652. He may have learned medicine from Thomas Pell and the Rev. Thomas Hooker. At any rate the community was very anxious to keep him, for the court granted him a salary of 15 pounds a year and established a fee table to which he agreed as follows: "For a visit to any house in Hartford 12 pence, in Windsor 5 shillings, in Farmington 6 shillings." The court also freed him "from watching, warding and training but not from finding armes, according to law."

Doctor Bryan Rosseter was one of the first settlers in Windsor and became the first town clerk. He was well educated and given a license to practice by the General Court. He removed to Guilford in 1652 and continued to practice, working as a surveyor as well. He seems to have performed the first recorded autopsy in Connecticut about 1662 and was voted by the General Assembly 20 pounds for "opening Kellies child." He engaged in many controversies and lawsuits and devoted considerable time to politics, although an active practitioner. He died in Guilford, September 30, 1672. Probably both Pell and Lord and also Rosseter had medical apprentices but no information in regard to this was found.

During the latter part of the 17th and 18th centuries and before any medical schools existed, there were a number of physicians who acquired considerable reputations as medical teachers. Perhaps the most noted of them were Gershom Bulkley of Wethersfield, Jared Eliot and Benjamin Gale of Killingworth (Clinton), Phineas Fiske of Haddam, Philip Turner of Norwich, Seth Bird of Litchfield, Doctor Hurlbutt of Berlin, Jared Potter of Wallingford, John Osborn of Middletown and Norman Morrison and Lemuel Hopkins of Hartford. I think only one of them had studied abroad, but it is interesting to note that the most distinguished of them were college graduates and many of them preachers as well. As it is impossible in the allotted time to discuss all of these, I have selected for consideration those who seemed most worthy and who represent different periods.

Rev. Gershom Bulkley a noted clerical physician was the son of Rev. Peter Bulkley and Grace Chetwood and was born December 6, 1636. He was graduated at Harvard in 1655 and married Sarah, daughter of President Chauncey. He went to New London in 1661 as its second pastor. In 1667 he became the pastor in Wethersfield, remaining there until 1677, when he retired from the ministry. It is not known where or when he studied medicine, but he evidently had early established a reputation, for in 1675 he was appointed by the court to be "chyrurgion" to our army. In 1676 the "Council" returned thanks to Doctor Bulkley for his service in the war and

ordered him paid the sum of 30 pounds.

In October, 1686, he was licensed to practice; why he was not licensed sooner we do not know. The license reads as follows:

This Court being well acquainted with the ability, skill, and knowledge of Mr. Gershom Bulkley, in the arts of phisick and chirurgery, doe grant him full and free liberty and license to practise in the administration of phisick and chirurgerie as there shall be occasion and he shall be capable to attend.

Doctor Bulkley served also as a magistrate and as surveyor and was interested in politics. He possessed a large library, was a diligent student and a voluminous writer. After resigning from the ministry he devoted his energies to law and medicine and was considered not only one of the most learned and skilled physicians of his time, but also an excellent linguist, being familiar with Greek, Latin and Dutch. He is said to have had a well equipped laboratory and was interested in experimentation, especially in chemistry. His patients came from Hartford, Springfield, Windsor and Middletown, as well as from his immediate neighborhood. He figured in perhaps the first recorded medico-legal case in the colony. Mercy Brown of Wallingford was charged with the murder of her son. It was known that she had fits of insanity and the court was in doubt what to do. So they applied to Doctor Bulkley for advice. He rendered the following very enlightened opinion:

If she were not *compos mentis* at the time of the fact it is no felony and consequently no willful or malicious murder; and if she be known to be a lunatic though she have her lucid intervals, there need be very good and satisfactory proof that she was *compos mentis* at the time of the fact committed, for the law favors life.

Doctor Bulkley was accustomed to make notes as he read. One of these notes relating to the treatment of rattlesnake bites follows:

Some say of Mr. Pell, that he was wont to say, the best and speediest cure was to stound (not kill) the Rattlesnake that had bitten any, and with a forked stick, fasten him to ye ground, and cut off a piece of him, and apply warme to the wound and so (ye snake being yet alive) piece after piece as fast as need should be, till it had drawne out all ye poison.

Another was for the cure of wind collicke as follows:

Wolfes gutts cleansed from ye filth, then washed over and over in oderiferous wine wherein wormwood hath been boiled, dry them in ye north wind, one dram of ye powder of ye guts, so prepared in oz. iij of wine or more (after a clyster given) is an excellent remedy for ye extreme pains of ye wind collicke.

Doctor Bulkley died in December, 1714, and was buried in Wethersfield. The writer was unable to ascertain the number and the names of his students or anything about his methods of instruction, but it is believed that he taught many students and was a very successful teacher.

Upon his monument is the following inscription:

He was honorable in his descent, of rare abilities, extraordinary in industry, excellent in learning, master of many languages, exquisite in his skill in divinity, physic, and law, and of a most exemplary Christian life.

In certam spem beatae resurrectionis repositus.

Jared Eliot of Killingworth (now Clinton), was born in Guilford, November 7, 1685, and died at Clinton, April 22, 1763, in his 78th year. He had an illustrious parentage, being the son of the clerical physician, Rev. Joseph Eliot of Guilford, and Mary Haynes Wyllys, daughter of Governor Wyllys and grandson of John Eliot, famed as the Apostle to the Indians.

On his father's side he was related to Sir John Eliot of England, and on his mother's side to English royalty. He was graduated at Yale, then located at Killingworth in the class of 1706 and was said to be the favorite pupil of Rector Pierson. A few years later he received an honorary A.M. from Harvard. The other two members of his class were Timotheus Woodbridge and Jonathan Dickinson who in 1747 became the first president of Princeton. The year after graduation Eliot taught school at Guilford and on the death of Rector Pierson in 1707 was called by the first church at Killingworth as advised by the dying rector. On June 1, 1707, he began his ministerial duties with an annual salary of 120 pounds but was not ordained until October 26, 1709. The sixty cords of fire wood per year which the church offered him if he would marry proved sufficient inducement as he quite promptly wedded Hannah Smithson of Guilford in 1710. Of his eleven children, two daughters and nine sons, one daughter died in infancy and the other married one of his pupils, Doctor Benjamin Gale. Three of his sons were graduated at Yale. Three of them became physicians and four served in the General Assembly for terms varying from three to fourteen sessions. As his wife and her family belonged to the Established Church and in view of his natural catholicity of spirit it is not strange that Eliot in October, 1722, signed with Rector Cutler, Tutor Brown and four others a statement that "Some of them doubted the validity, and the rest were more fully persuaded of the invalidity of the Presbyterian ordination." However, he was persuaded to continue orthodox and remained ever after an "Old Light."

In September, 1730, he was elected a trustee of Yale College, being the first of its graduates to hold that office and continued to fill this position till his death in 1763, having according to Mr. Dexter outlived every pastor in the colony who had been earlier ordained, and all who had graduated at the college before him. His will disposed of property valued at 1,800 pounds consisting largely of farms in various parts of Connecticut and iron mines located in Salisbury and Killingworth. Also this item appears: "I will and bequeath to the President and Fellows of Yale College in New Haven, ten pounds lawful money, the interest of which sum shall be applied to the use of the library, in buying of books from time to time according to their best skill." This was the beginning of the Yale library fund.

Doctor Eliot probably derived inspiration and help both in his theological and medical studies from his father, Rev. Joseph Eliot of Guilford, also a clerical physician and whose great abilities as a divine, a political leader and a physician were admired not only among his own people but throughout the colonies.

A detailed characterization of Doctor Jared Eliot, both mentally and physically, is given in his funeral sermon by his friend and neighbor, Rev. Thomas Ruggles, pastor of the First Church of Guilford. A copy of this rare book is in the possession of the Yale Library. In judging this eulogy some allowance probably should be made for the enthusiasm of an intimate friend. Doctor Ruggles says:

His person was well proportioned. The dignity, gravity and openness of his countenance were plain indications of the penetration and greatness of his mind and the agreeable turn of his conversation. He was favored with an excellent bodily constitution

capable of enduring all the fatigues of hunger and thirst, heat and cold, without sensible relaxation or weariness, which he faithfully improved in activity and incessant application in a great variety of scenes of life: Idleness was his abhorrence, but every portion of time was filled with action by him. Perhaps no man in his day has slept so little, and done so much, in so great a variety; and if the rule of judging of the length of life, be the measure of doing; perhaps he lived as long as the antediluvian patriarchs, who numbered so many hundred years in the course of their pilgrimage.

It is said that for forty years he never missed preaching on Sunday, either at home or abroad. Doctor Eliot is described as being mentally very keen and alert, a man of very excellent judgment in matters of business as well as professionally. His personality was charming, his disposition cheerful and his conversation bright and entertaining. He was very charitable to the views of others and very generous in his service to the community so that Mr. Ruggles says, "perhaps no man in his day, spent a life so long and so active, in a disinterested and perpetual endeavor for promoting the welfare of the world round about him."

He was evidently a good "mixer" for Mr. Ruggles continues:

"He had a turn of mind peculiarly adapted for conversation and happily accommodated to the pleasures of social life. . . . No less agreeably charming and engaging was his company, accommodated to every person under every circumstance. Nothing affected, nothing assuming. It was all nature and shined with wisdom: That perhaps no person ever left his company dissatisfied or without being pleased with it."

He had a taste for literature, was well versed in the polemical writings and familiar with the best writers. He was an enemy to all imposition and keen in his understanding of human nature. He was clever in the interpretation of symptoms and ingenious in treatment particularly in cases of extraordinary difficulty. To quote Mr. Ruggles further, "But that part of physic wherein he conspicuously excelled was the method of treating and the remedies he invented for the cure of that affective disease, the dropsy; whereby great numbers were released of their distresses, their lives preserved and their health and comfort restored to them."

Doctor Ayres of Newport, a former pupil of Doctor Eliot's, reported Doctor Eliot's treatment of dropsy at a meeting of the New Jersey Medical Society in 1766 and gave the composition of "a celebrated nostrum of the late Doctor Jared Eliot." This nostrum was called "Electuarium Stomachicum anti-hydropicum vel hystericum specificum, D.D. Eliot, novae angliae.

Pulv. Rad. Gentian} an ʒi
 Curcum }
 G Myrrh ʒss
 Glacci com. ʒiiss
 Cons. Rosar. vel. absynth. q. s. of Elect.

The dose of this was to be increased till "There would be felt in the stomach a severe pungent pain, and an universal shock, something like an electric stroke." Inasmuch as one of the ingredients was powdered glass we are not surprised at the following cautious vote passed by the society. "The society taking the above medicine into consideration, were greatly surprised at the accounts, but judged it not prudent to recommend the use of it without more authentic proof of its success."

When we consider the above formula and also other prescriptions of that period such as the *Electuarium Stomachicum* of William Salmon with its

twenty-eight ingredients, how marvellous must be *vis medicatrix naturae* that the patient is able to recover in spite of the deleterious effects of the treatment.

Doctor Eliot, like Benjamin Franklin, was so industrious that he improved his time while on his journeys on horseback by reading, which was a great gain as he was called in consultation to all parts of the colony and even to Newport and Boston.

He was also both a practical and scientific agriculturist and according to tradition was able to make his farms more profitable than any of his neighbors. He wrote a number of pamphlets on farming and introduced into the country the white mulberry tree and silk worm culture. Eliot was also a metallurgist and made perhaps this country's first contribution to that science in an "Essay on the Invention or Art of Making Very Good, If Not the Best Iron, From Black Sea-Sand." For this essay the London Society of Arts in 1762 presented him with a gold medal. This medal in 1905 was in the possession of one of his descendants, Mr. Charles G. Eliot, Goshen, N. Y., and a picture of it is in the geneology of the Eliot family. In 1756 he was unanimously elected a member of the Royal Society of London. His interest in metallurgy led him to invest in the iron mines in Salisbury and also in Killingworth.

He was on friendly terms with Bishop Berkeley, also with Benjamin Franklin who always stopped at his house, when journeying from New York to Boston. Eliot lived on the site now occupied by the home of Mr. George E. Eliot on the main street in Clinton, opposite the Congregational Church.

The Yale Library contains portions of Doctor Eliot's correspondence with Doctor Franklin, John Bartram, Ezra Stiles and several others. After a visit with Doctor Eliot, Franklin wrote: "I remember with pleasure the cheerful hours I enjoyed last winter in your company, and I would with all my heart give any ten of the thick old folios that stand on the shelves before me for a little book of the stories you then told with so much propriety and humor."

One of his stories which has been handed down by tradition in his family and which I learned through the courtesy of Mr. George Eliot is as follows. "He had been annoyed by repeated calls for attendance upon a woman in the village who was really as well as he was himself. He had tried in vain to convince her of her perfect health, and then in desperation sat himself down on the door step and grinding up his old clay pipe, folded it in the conventional papers and left the powders with minute directions for their use. The next day she stopped him again as he was riding by, and with an ebullition of gratitude exclaimed: "O, Doctor, I'm a different woman. Those powders were just what I needed." Was it also an example of subtle humor when he preached the funeral sermon of his mother-in-law from the text: "The Blessings Bestowed On Them That Fear God." Doctor William H. Welch in his address at the bicentennial of Yale University says "of all those who combined the offices of clergyman and physician not one from the foundation of the American colonies attained so high a distinction as a physician as Jared Eliot."

Thacher in his medical biography says, "Eliot was unquestionably the first physician of his day in Connecticut, and in chronic complaints he appears to have been more extensively consulted than any other physician in New England, frequently visiting every county in Connecticut, and being often called to Boston and Newport."

Because he trained so many medical students who afterwards became noted he has been called "The father of regular medical practice in Connecticut." While he probably trained more than fifty students I was able to find the names of only a few, viz.: Jared Potter, Benjamin Gale and Doctor Ayres of Newport. According to Thacher, Eliot was the last of the noted clerical physicians. A portrait of him is in the possession of Mr. George Eliot of Clinton and a photograph of this is in the book, "The Descendants of John Eliot."

Botanist, scientific and practical agriculturist, metallurgist, man of affairs, teacher, trustee of Yale, preacher, physician, and the first donor to the Yale Library fund—there was nothing more for him to do.

The writer has been able to find very little in regard to Doctor Eliot's armamentarium for teaching and methods employed. Whether he possessed a skeleton or demonstrated dissections or performed autopsies for the instruction of his students history does not tell us.

There are only two essentials for good teaching—one is an efficient and stimulating leader, and the other is an abundant opportunity for work on the part of the student. In the case of Jared Eliot we are sure that the first requisite was amply met.

Another well known teacher was Benjamin Gale, who was born in Jamaica, L. I., in 1715, the youngest son of John and Mary Gale. He was graduated at Yale in 1733, studied medicine with Jared Eliot, married his daughter Hannah in 1739 and practiced all his life in Killingworth (Clinton) Connecticut and died there May 6, 1790, in his 75th year.

President Stiles writes in his diary on hearing of his death, "A singular character! He was considerably learned and a very inquisitive man. A great friend to revelation and hated deists with perfect abhorrence. Believed in universal final salvation of all but deists and apostates, who were to be annihilated."

Doctor Gale was a man of great integrity and a very skillful physician. He built the stone house on the main street in Clinton on the hill just west of the Clinton river which is now the Village Inn. It is said that he built one stone house within another and that he used the inside one for anatomical work and his theological studies, although not a clerical physician. Dexter gives a list of his published papers, twelve in number. They are largely political and some of them were published in the newspapers. One was a letter to a member of the Lower House of Assembly of the Colony of Connecticut, with the title: "Showing that the taxes of Yale College are stated higher than necessary to defray the annual expenses of that school; by which a very considerable addition is made to the College Treasury annually. With some general Observations on the Laws and Government of that Society. By a Lover of Truth and his Country, New Haven, 1759."

Another paper was "Historical Memoirs relating to the practice of Inoculation for the Small Pox, in the British American Provinces, particularly in New England." This was read before the Royal Society, May 23, 1765, and published in full in their Philosophical Transactions for that year. Still another medical paper was "A Case of the Bite of a Mad Dog." Like his preceptor, Eliot, he was also interested in scientific agriculture and we have two papers on that subject: "The Natural History of Black Grass," published in 1766, and "Observations on the Culture on Smyrna Wheat" in 1783. He received a medal from a society in England for the invention of an improved drill plow and was elected a corresponding member of the Society of Arts in London in 1765.

In his paper on inoculation he gives some statistics in regard to the efficiency of inoculation in preventing small pox and especially showing the value of treating the patient with mercury and antimony previous to the inoculation. He says, "Before the uses of inoculation the mortality in small pox was 1 to 8, inoculation reduced the mortality to 1 to 100, and the use of mercury and antimony in preparing persons for inoculation, has reduced the mortality to 1 to 800." Doctor Gale also was a contributor to the publication "Cases and Observations by the Medical Society of New Haven County." According to Thacher "his reputation in medicine and other sciences was little if at all inferior to that of his father-in-law; and he also carried on a correspondence with distinguished American and foreign scientists." He was also interested in theological speculation and Biblical criticism and wrote a dissertation on the Prophecies.

Doctor Gale served as representative in the General Assembly at thirty-two sessions between 1747 and 1767 at which date he declined further service. From the evidence at hand it does not seem to the writer that Doctor Gale was the equal of Jared Eliot in balanced judgment, mental acumen or scientific ability.

Among his students were the following: Elihu Tudor, a distinguished physician of East Windsor; Moses Bartlett of Madison, Yale 1730, and his sons, Moses, Yale 1763, and Phineas, Yale 1764; Benjamin Hill of North Killingworth; Samuel Redfield of Guilford and Hezekiah Brainerd, Yale 1763, of Clinton.

Doctor R. W. Mathewson says in his biographical sketches that for three fourths of a century, i. e., during the lives of Eliot and Gale, Killingworth was the great resort for medical education and that the first medical treatise published in the colony was by Gale in 1760.

Doctor Gale was buried as directed by himself, with his feet toward his house, so that he could see it immediately when he arose from the dead, which he full expected in the year 1800.

Another of the clerical physicians was Phineas Fiske, who was born at Milford, Conn., in 1682, and was the son of Doctor John Fiske. He studied with Rector Pierson and was graduated at Yale, then located at Killingworth, in 1704. He then studied theology and medicine in Milford with his father. In 1706, the college having removed to Saybrook, he was appointed tutor. After Rector Pierson died, in 1707, he largely controlled the affairs of

the college till 1713, and it was during this period that the school first assumed "the form and regularity of a college."

He taught logic, physics, metaphysics and ethics and had about forty students under his charge during his connection with the college, the most eminent of which was the Rev. Samuel Johnson, the first President of the College of New York. In 1714 he assumed charge of the church at Haddam at an annual salary of £70 and died there October 17, 1738, in his fifty-sixth year. His estate was appraised at £2,700 pounds and it is said that his library, which was extensive, contained many medical works. He was of a philosophical turn of mind and held all such discussions in Latin, which he spoke fluently. He was very modest and retiring and disliked to appear as an author. His only published article was a sermon preached before the legislature at the general election at Hartford, a copy of which is in the Yale library. He also had a very judicial mind and it is said always studied both sides of a controversy. In the practice of medicine he was noted for the treatment of insanity and epilepsy. He probably became especially interested in epilepsy because his brother was an incurable case. His treatment of epilepsy was to make a strong impression on the alimentary tract by antimony, followed by the free use of castor, assafoetida and other antispasmodics. This was followed by a persistent course of iron.

While it is probable that he trained a considerable number of medical students, the only ones whose names we were able to find are Doctors John and Joshua Arnold of Middle Haddam. His large experience in college teaching must have been a valuable asset to him and greatly increased his efficiency as a medical teacher.

Of the medical teachers of the latter part of the 18th century, the most noted undoubtedly is Jared Potter of Wallingford. He was born in East Haven, Conn., September 25, 1742, was graduated from Yale in 1760 and died in Wallingford in 1810. His medical studies were begun under Doctor Harpin of Milford, Conn., and continued under Jared Eliot of Clinton. He began his practice at East Haven, Conn., in 1763, removing to Wallingford in 1772.

He was an uncommonly diligent student during his whole life. For many years, according to Thacher, he maintained a medical school in which several of the most eminent physicians of Connecticut were educated. Doctor Lemuel Hopkins of Hartford was his first and probably his most noted pupil. The writer has been unable to ascertain the names of his other pupils, with the exception of Josiah Hart of Kensington. Doctor Potter's interest in scientific investigation and in medical literature seems to have been stimulated by his early association with Jared Eliot. He was well acquainted, it is said, with both ancient and modern writers on disease and bought yearly all the new books which were useful and also was a constant reader of general periodical literature. He was considered very keen in the interpretation of symptoms and was particularly noted for his prowess in dealing with acute diseases, especially puerperal fever, pleurisy and dysentery. His skepticism in the efficiency of drugs in chronic diseases tended to limit his practice in this class of ailment. It is said that he never forgot the names and faces of

the people he met and the circumstances of the meeting, no matter how long a period may have elapsed. He was gifted with excellent powers of conversation and the courtesy of treatment extended to his colleagues, together with his reputation for skill, made him a very acceptable consultant and gave him a large practice. One of his prescriptions was very popular with physicians for more than fifty years. This was composed of camphor, ammonia, chalk and charcoal. He was very fond of discussing questions of speculative theology and politics, and his serenity, quick wit and humor usually gave him an advantage over his opponent.

He was active in the affairs of the Connecticut Medical Society, being one of its incorporators in 1792, and served the society as secretary for the first two years of its existence and would probably have succeeded Aeneas Munson as president had he not promptly refused to be considered. He, however, acted as vice president for the year. He also served with Aeneas Munson and Elnathan Beach on the first committee appointed by the Connecticut Medical Society as representatives of New Haven County for examination of the candidates for the "practice of physics and surgery."

In 1775 he was chosen surgeon of the first regiment of Connecticut, an indication that he had a good reputation in surgery also. He served as a fellow from New Haven County of the state society in 1793 and from 1796 to 1804, with the exception of 1803. The state society at its meeting October 17, 1798, conferred upon him the honorary degree of Doctor of Medicine.

In 1801 he served on a committee of the state society with Doctors Benjamin Gale and William Shelton to revise the by-laws of the society and also on a committee with Doctor John Bestor to present to the General Assembly a bill "for the purpose of ameliorating the medical treasury system."

The only criticisms of Doctor Potter that have been handed down to us are in regard to his theological speculations, which were said to be of an infidel character, and that his pupils were influenced by his skeptical ideas. Doctor Henry Bronson, in his Historical Account of the Origin of the Connecticut Medical Society, speaks of Jared Potter as the "foremost medical man of the State," and this seems to have been the general opinion.

When we consider the difficulties and the trials and tribulations to which the early settlers in Connecticut were subjected, the hardships and exposure which the medical practitioner was obliged to undergo, the scarcity of books, drugs and apparatus, the lack of medical schools and the general crudity of society, the writer feels that we should give great honor to those clerical physicians who, recognizing the great necessity for proper training in medicine, unselfishly and unstintedly gave of their time and talents and thereby rendered a great and noble service to the commonwealth of Connecticut.

It does not seem fitting to finish this recital of Medical Teachers in Connecticut without speaking of Connecticut's great service to surgical science through the discovery of anesthesia by Horace Wells, and also its great service to medicine through the work of William Beaumont, who substituted observed facts for speculation. Both of these men can be considered teachers of medicine in the best sense of the term.

GASTRO-INTESTINAL DISTURBANCES IN NERVOUS AND MENTAL DISEASE

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THE ASSOCIATION between gastro-intestinal symptoms and diseases referable to the nervous system is frequent. The relation, however, is the result of different mechanisms in various instances, and it is true that most focal lesions of the central nervous system have no gastro-intestinal components while most focal lesions of the gastro-intestinal tract have no coördinated lesions of the central nervous system. The word "diarrhea" appears once in the index of the second edition of Wechsler's "Textbook of Clinical Neurology", while the word "vomiting" is indexed only five times. Conversely the majority of gastro-intestinal compendia attribute little importance to the association of central nervous system disease. The importance of emotional factors and the need for including psychological considerations in treatment are, however, well emphasized by such gastroenterologists as Alvarez,¹ Sullivan,² and Jones.³ A number of psychiatrists have studied in detail the psychological patterns of small groups of gastroenterological patients, in which connection the psychoanalytic observations of Alexander and his co-workers⁴ are important. It is in this realm of disturbed neurophysiology in the broadest sense of the term that the gastro-intestinal and nervous systems are most frequently linked.

It is the purpose of this communication to review a wide range of disturbances in which the gastro-intestinal and central nervous systems are both affected and, where possible, to discuss the mechanism of such association.

Coincidental disorders of the gastro-intestinal and central nervous systems resulting from a common etiological agent:

There are a number of infectious, metabolic, and toxic disorders in which both the gastro-intestinal and nervous systems may be involved. Pernicious anemia and pellagra are probably pure deficiency disorders. The frequently observed gastro-intestinal disturbances in pernicious anemia include gastric

anacidity, atrophic gastritis, gastric polypi, and diarrhea, while the nervous system suffers from postero-lateral sclerosis and mild psychotic episodes. Pellagra, even more consistently, combines mental symptoms with diarrhea. In tropical sprue, where the *oidium albicans* plays a now largely discredited etiological role, fatty indigestion, deficiency, and associated mental disturbances of a mild nature are frequent.

Infectious disorders such as syphilis and tuberculosis may affect both systems. Meningitis, especially in children, is frequently accompanied by gastro-intestinal disorders. In pneumonia delirium and tympanites occasionally occur together. Almost all debilitating diarrheas are accompanied by a state of emotional "let down." Occasionally intestinal parasitic infestation affects the central nervous system. *Trichinella spiralis* has been recovered from the spinal fluid, while the fish tapeworm, *diphyllobothrium latum*, produces a disease identical with pernicious anemia.

Disorders of the thyroid gland also affect both systems. In myxedema the mind is slow, the appetite poor, and the bowel constipated, while in thyrotoxicosis there is nervous overexcitement associated with increased appetite and frequent bowel movements. Heavy metal poisoning classically produces intestinal symptoms. In lead poisoning the "dry gripes" are often associated with either wrist drop or toxic encephalitis.

Disorders referable to the gastro-intestinal tract in association with focal lesions of the nervous system:

Gastro-intestinal symptoms may arise directly as the result of a central nervous system lesion or they may arise as indirect concomitants. For example, any disease which produces a sudden rise in intracranial pressure may produce projectile vomiting. Likewise the vagus nerve may be stimulated through the medianlongitudinal fasciculus in disease affecting the vestibular apparatus such as acoustic neuroma or Meniere's disease.

In anorexia nervosa and Simmonds' disease the predominant manifestation is loss of appetite and

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cachexia. The latter disease is caused by atrophy of the pituitary body, the former disease being of psychogenic origin. True Simmonds' disease is extremely rare. This statement is attested by the observations of Albright and others to the effect that the great majority of clinical cases of Simmonds' disease show follicle stimulating hormone in the urine. Inasmuch as follicle stimulating hormone is a pituitary product good evidence is available that the pituitary is not totally atrophied in these persons.

Associated with the hypothalamic area is the cause for gastromalacia, a disease in which the gastric mucosa is congested, ulcerated, and bleeds freely. Gastromalacia is not infrequently observed following head injuries, and has been observed as a complication of brain surgery. Cushing⁵ observed the syndrome in patients on whom operations in the region of the hypothalamus had been performed and felt that such lesions might play a role in peptic ulcer. Other workers lent experimental proof to his observations. Fulton and Watts⁶ and Keller, Hare, and d'Amour⁷ succeeded in producing gastric ulcerations after experimental surgery of the hypothalamus in animals, while Light, Bishop, and Kendall⁸ produced similar changes by injecting small amounts of pilocarpine into the lateral ventricles of rabbits. More recently Banting and Hall⁹ produced similar changes in dogs by the constant intravenous administration of acetylcholine, and Manning, Hall, and Banting¹⁰ accomplished the same feat by prolonged faradic stimulation of the vagus. The establishment of this pathway from the hypothalamus to the mucosa of the stomach and intestines is of great importance. The hypothalamus is the seat of certain primitive emotions and is probably influenced to a certain extent by higher centers.

In addition to the focal lesions just described certain more generalized diseases, such as multiple sclerosis, have occasional gastro-intestinal manifestations, anorexia, incontinence, etc.

There are also certain illnesses closely related to the nervous system in which gastro-intestinal symptoms, or symptoms readily confused with gastro-intestinal symptoms, occur. Among these may be mentioned tabetic crises. The pain in tabetic crises is generally thought to be mediated through the sympathetic fibers of the coeliac plexus. The mechanism of the abdominal component of migraine is not clear. The cranial phase has been shown by Wolff and Graham¹¹ to be due to pulsations of great amplitude in the walls of the

arteries branching from the external carotid system. This is presumably in part under control of the autonomic nervous system, and indirectly under control of the central nervous system. The abdominal phase may be similar in nature. A third more-or-less peripheral nervous disease is herpes zoster. In this condition, particularly when it involves the lower intercostal nerves, abdominal crises indistinguishable from gall bladder pain may occur. The pain may appear before the vesicular skin eruption and produce a very confusing picture.

Gastro-intestinal manifestations of the major psychoses:

The gastro-intestinal problems associated with the major psychoses are usually important from the point of view of management rather than diagnosis. This is particularly true of the depressive phase of the manic depressive group, where torpor of the bowel is not only clinically but also radiologically observed.¹² In the routine care of depressed patients bowel management must be of secondary consideration only to the suicidal risk presented by such patients. In the manic phase of the same disorder frequent bowel movements are often observed. In this group of patients, as well as in some of those with other psychoses such as dementia paralytica, symptomatic psychoses, and schizophrenia, the problem of handling personal uncleanness is difficult.

In contrast to such problems of management there are a few major psychotic symptoms of a gastro-intestinal nature which are of diagnostic importance. Most of these are associated with the various psychological patterns observed in schizophrenia. In this disease delusions may acquire a character of somatic nature and have relation to parts of the body. Of these somatic delusions one of the commoner is the complaint that the bowel is dripping away or that bath water enters the rectum or vagina and fills the entire abdominal cavity. The psychological character of such complaints is at once apparent in the more clear cut cases, but in some instances, where the complaint is limited to the anal canal or rectovaginal septum the differential diagnosis from anatomical local disease is most difficult. A second psychological symptom, observed in the paranoid type of schizophrenia, is the fear that food is poisoned. When this fear is openly expressed its psychological character is immediately evident. It is a fact, however, that many patients with paranoid

schizophrenia are semi-aware that they have a mental disease, and as a part of this disease, they are very suspicious of any interlocutor. So the symptom presented to the doctor is frequently loss of appetite, or intestinal gas, or unexplained loss of weight, and it is only after prolonged conversation and observation that one learns why the patient can't eat. The food is no good, and some one is in on it.

Related to this problem is that of anorexia nervosa, described originally by Gull in 1882, and frequently confounded with the syndrome of pituitary cachexia about which Simmonds wrote in 1914. Richardson¹³ feels that the two diseases exist but that they are clinically inseparable. With the advent of tests for follicle stimulating hormone in the urine, evidence against complete pituitary atrophy in the majority of cases is now available, and one can be sure that most cases of so-called Simmonds' disease are in reality anorexia nervosa. The psychological pattern of anorexia nervosa is different in different instances, but the disease does not ring true for any of the common psychoneuroses. A number of the cases unquestionably occur in persons with not-too-manifest schizophrenia. Generally speaking, however, the motivation for starvation is not fear of poisoned food but rather the abnormal desire to kill one's self by starvation and in many cases this is apparently for spite. Richardson reports a higher incidence of cures than the author has observed. Many cases of anorexia nervosa terminate fatally.

Gastro-intestinal symptoms as manifestations of common psychoneuroses:

Although *anxiety states* properly are included among the psychoneuroses, from the neurophysiological point of view and particularly from the gastro-intestinal point of view, they merely represent exaggeration of normal mechanisms. Therefore in this discussion they are better included among the tensional disorders.

Aside from anxiety states which are discussed below, the principal classical psychoneuroses are *hysteria*, *obsessive-compulsive states*, and *hypochondriasis*.*

For clinical purposes hysteria is a disorder characterized by psychologically determined symptoms

of an obviously gainful nature. It differs from malingering only in that the psychological process is unconscious. The parts of the body affected by hysteria are normally under easy control of the cerebral cortex, and in instances where they involve muscle, they generally involve voluntary muscle. The patient with hysteria usually has a peculiar bland indifference to the presenting disorder. The commonest major hysterical symptoms are amnesia, skin anesthesia or unilateral blindness, and paralyses. However, pain and vomiting are equally well within range of the cerebral cortex and are sometimes exploited. The so-called "globus hystericus" or lump arising in the throat is a borderline manifestation which the author is inclined to include in the anxiety group of symptoms.

Patients with clear cut obsessive-compulsive states are particularly burdened with a rigid unyielding method of viewing problems, and are the victims of many quasi-purposeful tics and rituals. They have to do things "exactly so." Such persons often have an abnormally meticulous sense of cleanliness. In this group usually belong those patients who are most particular about the exact size, shape, consistency, and hour of the daily or twice daily bowel movement. These patients often have associated tension and frequently suffer from mucous colitis. This entity is discussed below.

Hypochondriasis is a disorder of self-centered interest and self-pity. It is customarily characterized by a whining recital of multiple complaints. It derives its name from the fact that most of these complaints arise from exaggeration of the normal bodily sensations below the ribs. Hypochondriasis is easy of diagnosis, but difficult to treat. There is no clear cut physiological or psychological explanation for the specific symptoms which include "gas", rumbling, lack of appetite, pain, constipation, etc.

Gastro-intestinal manifestations of emotional tension:

Gastro-intestinal symptoms such as dry mouth, furred tongue, lack of appetite, nausea, abdominal cramps, and diarrhea are well recognized among the normal bodily reactions to fear. These symptoms and certain readily derived modifications may occur in three groups of persons:

1. Psychologically normal, physically fit, under conditions of overwhelming social adversity, e.g. soldiers in line of battle.
2. Psychologically normal but in poor physical training. Asthenic persons and persons who are

*Phobias are difficult to classify. From the viewpoint of Freudian psychoanalysis they have the same unconscious psychological mechanism as hysteria, but clinically they appear more frequently in the obsessive-compulsive group.

physically "soft" are particularly subject to cardiovascular and gastro-intestinal irregularities under the influence of psychological or physical strains or less noxious nature. Such persons are particularly subject to states of prolonged emotional tension.

3. Psychologically abnormal. In this group are included those persons with anxiety arising from causes other than immediate social adversity. This group constitutes the true anxiety states.

The physiological reactions in these three groups are not essentially different. In all three there are cardiovascular, pilomotor, and other autonomic nervous system responses in addition to those affecting the gastro-intestinal tract. The gastro-intestinal symptoms outlined above are those occurring during relatively brief states of fear. In states of more prolonged tension certain associated symptoms are found, belching, sour eructations, and heartburn related to the upper gastro-intestinal tract and constipation of the so-called spastic type related to the lower gastro-intestinal tract. Upper abdominal symptoms are the more common and frequently occur without those affecting the bowel, while lower abdominal symptoms usually do not occur alone. Generally some belching, heartburn, or vague indigestion is associated with them. The lower abdominal group compose a not-too-clearly defined syndrome best known by the title "mucous colitis." Mucous colitis is characterized by constipation or diarrhea, with lower abdominal pain aggravated by colonic activity, and with mushy or pebbly stools of small calibre. A most complete clinical review of this syndrome is that of Friedenwald, Feldman, and Rosenthal,¹⁴ while the relation of emotional factors is stressed in the studies of Bockus, Bank, and Wilkinson¹⁵ and of White, Jones, and Cobb.¹⁶

The group of gastro-intestinal symptoms associated with fear and tension is an important one, first because of the difficulty in treatment by conventional methods, and second because adequate treatment may go so far in preventing ill advised surgery and unnecessary invalidism. A detailed outline of treatment for all types of functional gastro-intestinal disturbances is beyond the scope of this communication. Generally speaking the upper abdominal triad, heartburn, belching, and sour eructations, yield to regular small feedings of a bland diet with or without the use of atropine derivatives. Mucous colitis, in the constipation phase, usually is relieved by these measures plus the elimination of all cathartics and enemas. Mucous colitis in the diarrhea

phase, however, is a much more difficult problem. Antispasmodics relieve the cramps but do not relieve the diarrhea. A meticulously followed low residue diet is probably the one most important factor, while a thorough understanding of the patient's personal problems is a close second in importance. Persons with mucous colitis often have a particularly rigid method of thought which makes decisions difficult and frequently their tension arises in the face of a dilemma. An interested physician may often help in bringing about a decision and thus relieve an appreciable degree of tension and anxiety. In discussing problems with patients with mucous colitis the physician should be on the *qui vive* for evidence of resentment. Often the tension in such patients is a form of rancor aroused by resentment which for one reason or another cannot be expressed or relieved by retaliation.

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(Concluded on page 477)

NEUROLOGIC LESIONS THAT GIVE GASTRIC SYMPTOMS

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Doctor White has already presented so completely the various correlations between nervous disease and gastro-intestinal manifestations that I shall not attempt to systematize the matter further but merely discuss briefly some of those neurologic lesions which are likely to give gastric symptoms

Intracranial Tension and Vomiting:

VOMITING may truly be said to characterize intracranial disease almost as much as headache. This is particularly the case in children where vomiting not infrequently precedes all other symptoms by a few hours during the early clinical phase of meningitis. Vomiting often accompanies the "bursting" headache of intracranial tension and is likely to occur in the early morning. Although it is usually associated with nausea, it has no relation to meals. True *projectile* vomiting, which comes on suddenly without nausea, is really very rare. Its occurrence is certainly not essential to make one suspicious of the presence of either meningeal irritation or increased intracranial pressure. It occurs more frequently in cerebellar tumours of children than in any other condition. In fact headache may not be associated, especially in tumours in the region of the fourth ventricle, where vomiting is probably produced by direct irritation of the vagal centers in the medulla. Too much emphasis cannot be placed on the importance of a complete neurological survey of the child with persistent bouts of vomiting as otherwise precious time may be lost for the neurosurgeon.

Any space occupying lesion within the skull is capable of producing recurrent gastric symptoms—nausea, and "indigestion", as well as vomiting. Consequently it becomes imperative to search carefully for signs of intracranial pressure:—beginning papilloedema, weakness of one or both external recti, increased convolitional markings on the inner table of the skull on roentgenographic examination, or increase in the spinal fluid pressure on lumbar puncture. The finding of focal neurologic signs may of

course give the clue to the situation, but these are frequently absent in the early stage of increasing intracranial pressure.

Tumour of the brain is of course the chief lesion under suspicion but the possibility of an abscess should always be kept in mind, especially of the cerebellum, where vomiting is a prominent feature. However, in my experience, the presence of a subdural haematoma is most likely to be missed under such circumstances. Chronic gastric symptoms are likely to be associated with this obscure, insidiously expanding clot over one or frequently both hemispheres of the brain. Lateralizing motor, sensory, or pyramidal reflex signs are likely to be minimal or absent and the fundi often remain negative for a long time. The history of head trauma, even though trivial and not necessarily causing a concussion, is the important clue. The spinal fluid findings—xanthochromia, increased pressure and increased total protein—are confirmatory, and diagnosis and treatment accomplished by trephine—a simple surgical procedure not sufficiently exploited.

Subarachnoid Hemorrhage:

The dramatic clinical picture associated with the sudden rupture of a meningeal vessel into the subarachnoid space is well known to all of you. The patient experiences a terrific pain in the head, as though "something snapped or cracked inside", the headache soon becomes agonizing accompanied by repeated vomiting and soon followed by profound weakness. The development of a stiff neck and finding of blood in the spinal fluid establish the diagnosis.

However, in the case of slow leakage into the subarachnoid space the signs of meningeal irritation may be minimal or even absent. Dull headache, giddiness, and waves of nausea with or without vomiting are likely to be the presenting symptoms. Such a patient is likely to have a slight fever (100-101 degrees) and a slow pulse (50-60). In my experience an erroneous diagnosis of food poisoning, intestinal "flu", migraine, or some functional nervous or gastro-intestinal disorder has often been made. The recovery of a slightly bloody or xanthochromic spinal fluid establish the diagnosis. Repeated con-

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servative spinal drainage under manometric control usually causes marked amelioration of the gastric as well as other symptoms.

Neuro-Syphilis and Gastric Symptomatology:

The remark has often been made that syphilis can simulate any disease. And so it is with neuro-syphilis and gastric symptomatology. The classical "gastric crisis" of tabes is easy to recognize clinically. However, these occur in only 10% of tabetics. Far more numerous are the patients with recurrent gastric distress not necessarily paroxysmal in type or accompanied by severe pain or continuous vomiting. In fact the symptoms may closely simulate either ulcer of the stomach or gall bladder disease. Pylorospasm can frequently be demonstrated on fluoroscopy and symptomatic relief afforded by adequate dosage of belladonna.

A thorough neurological survey will frequently uncover minor but significant changes—such as inequality and sluggishness of the pupils, optic atrophy, reflex abnormalities, especially loss of the ankle jerks. Sufficient attention has not been called to the relatively frequent presence of areas of cutaneous hypoalgesia. These have a predilection for the nose, anterior chest at the nipple level, inner surface of the arms and distal portion of the lower limbs. A negative blood serology fails to reveal the underlying disease of the nervous system in many cases. The most important diagnostic measure is of course examination of the spinal fluid. In 1922 Stokes analyzed 200 syphilitic patients at the Mayo Clinic whose chief complaint was "stomach trouble." 35 of these, or 18%, had had needless abdominal operations, whereas in all but two patients there were definite clinical clues to the underlying syphilis.

Experience from cordotomy in the treatment of the gastric crisis of tabes has brought out some interesting points. Cutting the spinothalamic tract on both sides of the cord relieves the intense pain, but the nausea and vomiting may persist. This suggests that the gastric symptoms are vagal in origin or at least related to the vegetative components of the nervous system whose pathways would not be interrupted by cordotomy.

Nerve Root Irritation and Upper Abdominal Pain:

Inflammation or compression of one or more of the posterior nerve roots in the mid dorsal region will cause upper abdominal pain. When this occurs gall bladder or stomach disease is often suggested

and the patient may be needlessly explored because of the persistence, severity and constant localization of the pain in the right upper quadrant. Muscle spasm is mistaken for segmental hyperaesthesia. The demonstration of a hyper-sensitive band of skin running slightly obliquely from above downward from the spine in back to the mid line in front is the real clue to the situation. The following case is illustrative.

A 44 year old woman complained of recurrent bouts of intense upper abdominal pain for the past 3 years, sometimes associated with eructation and mild nausea. "Tenderness" and "muscle resistance" had been noted repeatedly in the right upper quadrant. The Graham test proved equivocal. Exploration was negative and her symptoms remained unrelieved. Neurological examination revealed hyperaesthesia of the right 6th and 7th thoracic dermatomes, slight diminution of sensation below T.7 on the left side of the body, diminution of the right abdominal reflexes, and an extensor plantar response on the right. These findings indicated a spinal lesion at the 6th thoracic root level compressing the cord on the right side. The presence of a tumor was further suggested by reproduction of the pain by coughing, sneezing or straining at stool and demonstration of tenderness over the 6th and 7th dorsal spines. On laminectomy in this region an intradural, extramedullary tumour was found attached to the 6th dorsal nerve root on the right. This, which proved to be a neurofibroma, was easily removed and the patient has remained free of symptoms to date.

Migraine:

The common accompaniment of periodic hemi-crania by nausea and vomiting is responsible for the term "sick headache." Vomiting may persist to the point of bile emesis. Some patients claim relief of the headache by inducing vomiting. This effect can often be reproduced by an injection of ergotamine tartrate—0.25 to 0.5 mg. In this connection it should be pointed out that although the individual attack may be aborted, there is not likely to be any decrease in frequency and, as a matter of fact, in some cases the spells occur more frequently. There is no doubt of the authenticity of certain attacks of "abdominal migraine" without headache. Although the etiology is not established an allergic basis for the disorder seems probable.

The Hypothalamus in Gastro-Intestinal Regulation:

A discussion of the relationship between neurologic lesions and gastric symptomatology would be incomplete without reference to the role of the hypothalamus. The first experimental work on the central nervous system along these lines was that of Schiff who noted in 1867 that experimental lesions in dogs and rabbits involving the optic thalamus and adjacent cerebellar peduncle would often lead, after a few days, to softening of the stomach and even to actual perforations. Cushing reopened this whole question by reporting pylorospasm, retrograde peristalsis, vomiting, and other manifestations of parasympathetic activity after injection of pituitrin or pilocarpine in the lateral ventricle of man. He later presented startling evidence of a neurogenic factor in the etiology of peptic ulcer in his Balfour lecture at Toronto in 1932. During the past eight years numerous papers have appeared offering further clinical and pathological data to substantiate this claim.

Recently Sheehan* has admirably summarized the whole situation as it now exists, as follows . . . Adequate stimulation of the hypothalamus in animals is followed by inhibition of peristalsis and diminished muscle tone in the stomach and small intestine, and by an increase in the mucous content of the gastric juice with a tendency to diminish its rate of flow, (sympathetic effect). Motor responses of the stomach and intestine and a greater flow and increased acidity of the gastric juice, following stimulation more anteriorly, in the supra-optic and pre-optic areas, have been recorded by some observers, (parasympathetic effect). However, the experimental evidence for a parasympathetic center in the hypothalamus is by no means as well established as that for a sympathetic center.

*Proceedings, Association for Research in Nervous and Mental Disease, Vol. 20, 1939, 589-617.

Hypothalamic injury involving the tuberal and to a lesser extent the supra-optic regions is followed by mucosal hemorrhage and erosions in about one-third of all experiments. Gastro-intestinal changes may also be produced by lesions placed in the mid-brain and pons and transections of the spinal cord, all involving probably descending pathways in the autonomic nervous system. There appears to be a close similarity between the gastro-intestinal lesions produced by hypothalamic injury, by vagal nerve section, by bilateral adrenalectomy and the acute digestive crisis accompanying tumors of the brain, or following intracranial operations. A similar mechanism probably operates in all cases.

The relationship of such hemorrhage and erosion of the gastro-intestinal tract to chronic peptic ulcer is still obscure. It has been suggested on purely theoretical grounds that irritation of the vasoconstrictor sympathetic center would lead to a spasm of terminal vessels of the submucosa of the gastro-intestinal tract with consequent production of areas of ischemia and hemorrhage. Subsequent digestion of the necrosed tissue by the acid gastric juice would lead to crater formation.

However, this is far from proven. The hemorrhage and multiple mucosal erosion, both of the experimentally produced lesions and those associated with intracranial tumors, are usually found in the lower end of the esophagus and in the cardiac end of the stomach. When they occur in the body of the stomach they more often effect the greater than the lesser curvature. Although found in the pylorus or duodenum they are not confined to the upper end of the gastro-intestinal tract. They may occur even in the colon or mouth. True peptic ulcer, on the contrary, has a predilection for the lesser curvature, the pylorus and the first part of the duodenum. Also the abrupt onset and rapid course of the experimentally produced erosion is rarely seen in the history of peptic ulceration.

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HYPERNEPHROMA WITH METASTASES TO SCAPULA

Case Report

L. L. TYLEC, M.D., *Waterbury*

The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the JOURNAL. The following from St. Mary's Hospital (Waterbury) is the sixth in the series. (The Editor.)

THE LARGE majority of renal new growths whatever their origin, are malignant and, if untreated, more or less rapidly fatal. About 1 in 400 adults develop renal neoplasms. Hypernephroma comprise 60-85 per cent of all malignant tumors of the kidney of which 60-70 per cent occur in males between the ages of forty and sixty years. Although there are no pathognomonic symptoms, intermittent hematuria and mass or dull aching pain in the loin in the middle aged individual are suggestive and should be confirmed by urography. These tumors metastasize by blood stream to bones, lungs, and liver, occasionally to renal vein and vena cava. Metastases may occur in absence of symptoms pointing to renal tumor as is shown in the following case report.

Mr. H. H., age fifty-five, referred to hospital July 29, 1940, via Out Patient Department, complaining of pain in left shoulder, region of scapula, of thirty months duration.

Present illness dates back to two and one half years ago at which time he experienced recurrent attacks of burning pain in the left shoulder, occurring after strenuous work, subsiding with rest. At times pain would radiate down outer side of arm to elbow. Various home remedies failed to bring relief. Loss of weight during present illness, ten pounds.

Past history, other than diphtheria at the age of three, submucous resection in 1930, not remarkable. Cardio-respiratory, gastro-intestinal and genital urinary history negative.

Family history not remarkable.

PHYSICAL EXAMINATION

Well developed and nourished white male in no distress. Other than false teeth, cryptic tonsils, systolic murmur over precordium, the examination was negative except for a marked tenderness over the axillary border of left scapula with a slight fullness as compared to opposite side. Abdomen was negative for palpable masses and tenderness. Rectal examination was negative.

LABORATORY EXAMINATION

Urine was negative except for occasional pus and red cells.

R.B.C.—4,090,000 Hgb.—76% W.B.C.—10,680 P—76%

Kahn negative on two occasions. Blood chemistry within normal limits.

X-ray examination of left scapula showed malignancy of scapula involving axillary border and extending on to wing.

X-ray of chest, pelvis, and both femora were negative.

Patient was taken to the operating room and under gas oxygen anesthesia biopsy of left scapula was done. Patient was discharged the following day and was advised to return upon report of biopsy, which was metastatic hypernephroma.

On August 18, 1940, two weeks later, patient was readmitted to the hospital complaining of severe unbearable pain in right lumbar and sacro-iliac region radiating to posterior aspect of right thigh. Pain was relieved by narcotics. Examination on this admission same as previous, except for tenderness in right costo-vertebral angle and right sacro-iliac region, especially on motion of right lower extremity.

LABORATORY EXAMINATION

Urine showed moderate number of red and pus cells on three occasions.

R.B.C.—4,400,000 Hgb.—81% W.B.C.—9,800

Blood chemistry, NPN and sugar normal. Kahn negative.

X-ray examination on this admission—lumbar spine and pelvis negative. Kidneys not visualized. Retrograde pyelograms showed an enlarged right kidney and tumor of upper half, slightly involving the pelvis.

In view of metastases already present any surgical treatment seemed inadvisable, thus patient was put on x-ray therapy, being discharged September 3, 1940, symptom free and advised to return for further x-ray therapy.

Patient was last seen on January 30, 1941, at which time he was presented at tumor clinic. Since institution of x-ray therapy he has been free from pain except for occasional slight pain in left shoulder. Has had no need for narcotics or analgesic drugs and has had no gross hematuria. He has gained fourteen pounds in weight and wants to return to work.

On February 2, 1941, check up intravenous urography and x-ray of chest showed no changes. Check up laboratory examination:—R.B.C.—3,630,000; Hgb.—61%; W.B.C.—6,800; moderate achromia.

Report of x-ray therapy and discussion by S. M. Atkins, M.D., Radiologist:

Roentgen therapy was applied through anterior and posterior and lateral right kidney for effect on the lesion and to the left shoulder both for effect on the lesion and as anesthesia for the pain.

The prescription was 200 KV—MA 10 Filter Cu $\frac{1}{2}$ AL₃—Distance 50 cm.

To the kidney through 20-20 cm. portals one per day of about 250 r to alternate fields till each received total of 2500 r.

To the shoulder through anterior and posterior portals, one per day of about 250 r to alternate fields till each received about 1500 r.

Discussion by J. O. Collins, MD., Pathologist:

Projected on the screen you see a section of the biopsy removed from the scapula. As you see, the tumor is made up of large cells with clear cytoplasm and small eccentrically placed nuclei giving them a typical "signet ring" appearance. The picture is characteristic of hypernephroma, although the clear cell papillary adenocarcinoma of the kidney may present a similar picture in small isolated areas.

The remarkable feature of this particular case is the long duration of symptoms resulting from metastasis without any symptoms referable to the primary tumor. This was the third kidney tumor we have seen.

The first symptoms were those resulting from metastasis. In one case a sixty year old woman complained of tumor nodules in the scalp which first appeared some six weeks before she consulted her physician. These nodules resembled wens and five of them were removed. They were found to be metastatic hypernephroma. There was no hematuria until six months later. Three months after the onset of hematuria the patient came to autopsy and a large hypernephroma of the left kidney was found. The other case complained of pain in the sacro-iliac region on the left and down the left leg of about three weeks duration. X-rays showed metastasis to the lumbar spine and this was confirmed two months later at autopsy when a large hypernephroma of the left kidney was found. Thus, in certain cases, symptoms referable to the primary growth in the kidney may not appear until long after metastases have occurred.

Discussion by C. H. Neuswanger, M.D., Urologist:

This patient represents one of those rare cases of malignancy of the urinary tract where the first sign is a distant metastatic lesion.

Without some urinary symptom as a lead it is difficult to see how an early diagnosis could have been made. It seems most likely that this is a hypernephroma of the right kidney.

Our English Guests

Last July a company of 150 mothers and children, out of England, disembarked somewhere in Canada. They composed the vanguard of women and children seeking asylum in Canada and the United States for the duration of the war. In particular, they were wives and children of Oxford University dons, come to this side of the Atlantic at the invitation of Faculty Committees of Swarthmore College and Yale University, as well as personal friends and relatives. 126 members of the original group were cared for at Yale and at the Children's Center in Hamden and from there were passed on to friends and relatives as prearranged, or to foster homes provided by the Swarthmore Committee. 18 mothers and 75 children remained in the care of the Yale Faculty

Committee and to this group have been added 13 more mothers and children from Cambridge, London and Oxford Universities.

The Federal Government wisely provided that proper care and supervision be exercised in the placement and maintenance of such overseas guests. Doctor Grover Powers of Yale Medical School has supervised the health program. The education of the children has been carried on as near as possible at the same level as in England. Each guest was permitted to bring over the American equivalent of ten pounds sterling. The Yale Faculty Committee has assumed full financial responsibility for the support of its guests. The husbands and fathers of these Oxford mothers and children have already set aside more than ten thousand pounds for the purpose of reimbursing individual American hosts, but it is the hope of the Committee that this fund may be used to promote commerce between Yale and Oxford when the present world conflict is over, looking toward the establishment of a saner social order, world wide in its intention and scope.

News Item

As much as we individually might be in sympathy with the "Bundles for Britain" movement, one recent phase of it hardly has our approval.

At several points in the country there has been a movement to collect the samples left by pharmaceutical detail men in physicians' offices and include them in the shipments for British Relief. This is an expensive and uncontrolled way of supplying pharmaceutical products.

Most all of the pharmaceutical manufacturers have individually donated supplies with vitamin capsules and other needed pharmaceutical products to the British Relief at no charge.

The packaging of a sample increases the cost and if these samples are collected and sent to Britain, then the purpose for which they were intended, that is, for the use of physicians, is not accomplished, and the heterogeneous material that reaches British Relief probably would have little value. Many samples left by physicians would be dangerous if used indiscriminately without the advice of a physician.

In some cases individual City and County Medical Societies have been asked to cooperate with the collection of these samples. It is our opinion that such cooperation should be refused for the obvious reasons stated.

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

EVALUATION STUDIES OF LABORATORIES PERFORMING SERODIAGNOSTIC TESTS FOR SYPHILIS

The Statewide Evaluation of Laboratories in Connecticut

FRIEND LEE MICKLE, SC.D. AND EARLE K. BORMAN, M.S., *Hartford*

The Significance of Evaluation Studies

AS POINTED out in an editorial¹ in the Journal of the American Medical Association, it is now possible for the first time in the history of the United States for public health laboratories to ascertain the reliability of their serologic test performances on the two-fold basis of comparison of results in different laboratories and of checking serologic results with carefully evaluated clinical diagnoses on the donors of the specimens. The editorial refers not only to the evaluation studies carried on during the past five years by the United States Public Health Service with the various state departments of health, but to similar studies of local laboratories which now either are being carried on or are proposed for the near future in several states. In the editorial, active support of the medical profession of the country is urged for this attempt to improve the performance of serologic tests for syphilis because it is felt that for the first time an opportunity is presented for better administration of the various laws pertaining to the control of syphilis, including modern premarital examination laws patterned on the plan of the Connecticut law which took effect in 1935 and prenatal blood-test laws which have been adopted in several states. The stimulus of these studies is bound to result in almost unbelievable improvement in performance of serodiagnostic tests throughout the nation. The medical profession of Connecticut has already evidenced its support of the extension of these studies into Connecticut by making it possible for every laboratory in the state to enter such a study.

Connecticut Plans a Study

Participation in a statewide study offers the only known practical means for determining the com-

parative efficiency of local laboratories. Because the physician must consider the welfare of his patients he insists on knowing that any laboratory to which he sends specimens is having its serodiagnostic tests checked periodically by a suitable type of evaluation. For reasons of like nature, the Public Health Committee of the Connecticut State Medical Society, after thoughtful consideration, requested the State Department of Health to take steps toward the carrying out of such a study in this State during 1940 and 1941. The plan drawn up by that Committee received the approval of the State Medical Society and the Connecticut Association of Public Health and Clinical Laboratories and the following committee was appointed to carry on the study:

Robert Agnew, M.D., Norwich
 Creighton Barker, M.D., New Haven
 Paul H. Brown, M.D., Stamford
 Jessie W. Fisher, M.D., Middletown
 F. E. Kunkel, M.D., Hartford
 Alfred Labensky, M.D., New London
 Richard J. Lawton, M.D., Waterbury
 Clifford D. Moore, M.D., Newtown
 Paul D. Rosahn, M.D., New Britain
 D. E. Shea, M.D., Hartford
 George H. Smith, PH.D., New Haven
 Maurice J. Strauss, M.D., New Haven
 Henry P. Talbot, M.D., Hartford
 F. C. Weise, M.D., Bridgeport
 Carl H. Wies, M.D., New London
 Stanley H. Osborn, M.D., Hartford, Chairman
 Friend Lee Mickle, SC.D., Hartford, Alternate Chairman

Under the auspices of the Committee a questionnaire was sent to the heads of all laboratories in Connecticut known to the State Department of Health to be making examinations of body fluids and exudates whether or not these laboratories are performing a test for syphilis. By circularizing all laboratories it was hoped to make the study truly

Director and Assistant Director, Bureau of Laboratories, Connecticut State Department of Health

statewide in scope by offering every laboratory director and serologist an opportunity to take part in the studies to be undertaken in the fall of 1940 and the spring of 1941.

The Situation in Local Laboratories

Of the 98 laboratories circularized, 91 replied to the questionnaire. The heads of 44 laboratories signified their desire to participate. Only one of the remainder is known to be performing tests for syphilis. The laboratories designated as wishing to participate are distributed as follows:

- 23 in general hospitals
- 9 in private laboratories
- 6 in state hospitals and sanatoria
- 4 in city health departments
- 1 in an insurance company
- 1 in a federal institution

Certain laboratories are performing more than one test for syphilis so that requests have been received for evaluation of the following tests:

- Standard Kahn test, 24 laboratories
- Kline diagnostic test, 12 laboratories
- Kline exclusion test, 10 laboratories
- Hinton test, 8 laboratories
- Kolmer complement-fixation test, 6 laboratories
- Other complement-fixation tests, 5 laboratories
- Eagle flocculation test, 1 laboratory
- Davies-Hinton test, 1 laboratory
- Ide test, 1 laboratory
- Laughlen test, 1 laboratory

A considerable volume of serodiagnostic work is done in the local laboratories throughout Connecticut. Replies to the questionnaire indicate that 150,474 tests were performed in those laboratories in 1939 as follows: Standard Kahn, 65,154; Complement-fixation, 35,088 (including 10,164 Kolmer tests); Hinton, 21,469; Kline exclusion, 14,906; Kline diagnostic, 8,503; Laughlen, 2,932; Davies-Hinton, 1,499; Ide, 600; Eagle flocculation, 323. This is in addition to the 68,867 Kline exclusion, 16,484 Hinton and 17,319 "Connecticut" complement-fixation tests performed in the Bureau of Laboratories in 1939.

No system of checking tests comparable to an evaluation study of this type has been followed by any of the laboratories, the questionnaire revealed. Some have checked a few specimens by examining them in duplicate with other laboratories but without systematic clinical selection of cases. Some have apparently felt it sufficient to check a test of one type by running another of a different type.

A certain measure of standardization of technic appears to have been achieved in Connecticut. According to the replies, 8 laboratories doing the Kline

test, 9 the Kahn, 4 the Kolmer, 3 the Hinton and one the Eagle flocculation are following the technics described in the latest publication of the author (Supplement 9² to Venereal Disease Information) either directly or through the mimeographed Approved Methods furnished by the Bureau of Laboratories. The head of each laboratory approved by the State Department of Health has signed an agreement to follow a method approved by the Department for each test performed in that laboratory. Although laboratories merely registered as required by law may use any preferred technic, it was surprising to find that some registered laboratories are following descriptions of tests dating back a considerable number of years and differing from recent descriptions in many respects, while a few are depending upon technics published by supply houses. A few of the laboratories circularized are following original technics developed in the laboratories themselves or handed down from another laboratory.

The sources of antigens used for serodiagnostic work throughout the State vary widely. A few laboratories have been obtaining antigen from the authors of tests used, a few have been preparing their own antigens but the greatest number have been purchasing antigens from supply houses. The latter group shows a wide range of sources, some of these sources doubtless being poorly equipped to control their products by effective clinical trial.

The 1940 Study

Twenty one laboratories entered the 1940 Study for which detailed plans had been made by the Advisory Committee of Coöperating Physicians. Most of these laboratories were located in hospitals both large and small; some were private laboratories; a few were city board of health laboratories. More laboratories wished to enter the first study but it was impossible to accommodate them so the Advisory Committee decided that a selection must be made that would be representative of the State as a whole. It is planned that the remainder of the laboratories will be included in a Study which will probably be under way when this appears in print as it is tentatively scheduled for March and April of 1941.

Three laboratories, each of which has been evaluated in nationwide studies, were designated as control laboratories for both studies. The Venereal Disease Research Laboratory, U. S. Marine Hospital, Stapleton, S. I., N. Y., is serving as control for the following tests: Standard Kahn, Kolmer complement-fixation, Kline exclusion, Kline diagnostic and

Eagle micro-flocculation. The laboratory of Charles R. Rein, M.D., 580 Fifth Ave., New York, N. Y., serves as an additional control for the Kline exclusion and Kline diagnostic tests. The Bureau of Laboratories of the Connecticut State Department of Health serves as control for the standard Kahn, the Kline exclusion and the Hinton tests and for complement-fixation tests by performing the Connecticut complement-fixation test. In addition, the Venereal Disease Research Laboratory performed the Eagle macroflocculation test and both Doctor Rein's laboratory and the Bureau of Laboratories performed the Mazzini test.

In the 1940 Study sufficient blood was drawn from 33 syphilitic donors and 29 non-syphilitic donors to submit a portion of each specimen to each one of the participating and control laboratories. Specimens were identified by number only so that no serologist knew from which type of donor the specimen had been drawn. Weekly reports were submitted by all laboratories for tabulation and analysis. The syphilitic donors had been selected by a committee of physicians to include a majority of cases which had been subjected to rigorous specific treatment for varying lengths of time. All of the non-syphilitic donors were individuals apparently in good health at the time specimens were taken.

Manner of Rating Laboratories

Based upon the results submitted in the 1940 series, each of the control and participating laboratories was given a "Sensitivity Rating" (a measure of the ability of the laboratory to detect syphilitic reagin when present in the blood in moderate and small amounts), and a "Specificity Rating" (a measure of the ability of the laboratory to obtain clearcut negative results on specimens from entirely normal non-syphilitic donors). Sensitivity was calculated as the percentage of positive reactions in the group of syphilitic donors by allowing full credit for "positive" reports and a half credit for each "doubtful" report. Specificity was similarly calculated from results on non-syphilitic donors except that "demerits" were charged instead of "credits." This was done in strict conformity with the procedure followed in national evaluation studies.

The National Advisory Committee of the U. S. Public Health Service has recommended that a laboratory qualify as satisfactory only when (1) its sensitivity rating in a given study is not more than 10 per cent below that attained by the control

laboratory performing the same test and (2) its specificity is 99.0 or better.

It is not proposed to attach full significance to sensitivity and specificity ratings in the 1940 State-wide Study since the series of specimens submitted was too small to justify such sweeping conclusions. However, the director of each laboratory has been furnished with full results so that he may compare ratings with those of control laboratories performing the same test to determine how closely the desirable result has been approximated. It had been pointed out to participating laboratory heads that a large spread between results in a participating laboratory and those in control laboratories indicates urgent need for improvement in the participating laboratory; also that false reactions in greater proportion than one full demerit (1 positive or two doubtfuls) would still disqualify a laboratory even if the number of non-syphilitic donors were increased to more than 100. Following a meticulous study of the results, specific recommendations concerning means of improving tests have been transmitted to each laboratory head and it has been recommended by the Advisory Committee that the State Department of Health undertake the task of advising laboratory heads on carrying out these recommendations.

Sensitivity of Tests

A wide difference in sensitivity between various types of tests was noted. It must be emphasized here that these figures may have no real significance in the selection of a test to be performed routinely in a given laboratory. In a larger series greater uniformity between tests might have been shown.

The following tests are now recognized throughout the country as evaluated procedures: Standard Kahn, Kolmer complement-fixation, Kline diagnostic, Hinton, Eagle flocculation and Eagle complement-fixation. In addition, the Connecticut complement-fixation test is recognized as satisfactory in this state since it has consistently given results comparable to the Kolmer quantitative complement-fixation test in national surveys. The Kline exclusion and Kahn presumptive tests are recognized as satisfactory only for "screen" purposes; the reporting of doubtful or positive results by these tests is not considered advisable.

General Observations on 1940 Study

The Advisory Committee has recommended that publication of detailed results of the Connecticut

Statewide Evaluation Study be postponed until the completion of the project in April, 1941. However, certain facts and observations brought out by the first study are of immediate concern to all and may be mentioned here. Nearly every participating laboratory showed a need for improvement, some in greater degree than others. The Advisory Committee recommended that the head of each laboratory take steps to determine how much improvement can be effected and for that purpose instructed the State Department of Health to make certain general observations for the guidance of laboratory directors. These are appended:

GENERAL OBSERVATIONS ON PERFORMANCE OF SERODIAGNOSTIC TESTS

1. Laboratories performing tests not recognized as standard and not comparing favorably with standard tests can improve results by adopting tests which have been given thorough trial in nationwide studies.

2. Laboratories should be following the latest technic of the author of each test. The State Department of Health distributes mimeographed copies of these latest technics to approved laboratories and copies are obtainable upon request. Supplement 11 to Venereal Disease Information (June, 1940) also contains the latest published descriptions by Eagle, Hinton, Kahn, Kline and Kolmer. It may be obtained for 15 cents (in coin) from the Superintendent of Documents, Washington, D. C.

3. Results of tests should be interpreted as "Positive," "Doubtful" or "Negative" in conformity with recommendations of the author, not as considered advisable by the individual serologist or laboratory director.

4. Positive and doubtful reactions by "screen" exclusion or presumptive test procedures should not be reported to physicians.

5. Because of the wide discrepancies occurring between different tests and that are possible between two tests of the same type in different laboratories, it is recommended that all tests be reported to physicians as "Positive," "Doubtful" or "Negative" without other symbols such as 1+, 2+, 3+, 4+, strong, weak, etc. since these designations give a false impression of quantitative significance. Exceptions should be made only for tests of a quantitative nature.

6. Standard antigens when purchased should be from sources approved by the author of the test used

and preferably should be antigens that have been checked by the author.

7. Antigens prepared by a laboratory should be standardized and checked very carefully against an antigen already passed upon by the author of a test.

8. If unsatisfactory results in a laboratory cannot be explained on the basis of technic or interpretation, the serologist should seek training either (1) in the laboratory of the author of the test or (2) in a laboratory which has attained satisfactory performance in a national evaluation study. This period of training should be sufficiently long to satisfy the training laboratory that proficiency has been gained.

REFERENCES

1. Anon., Journal of the American Medical Association, 115, 5, (August 3, 1940).
2. Recently revised as Supplement 11 to Venereal Disease Information U. S. Public Health Service, June, 1940.

Record Lows for Maternal and Infant Mortality

Maternal and infant-mortality statistics for 1939 have just been issued by the United States Bureau of the Census. The maternal mortality rate for the year was 50 per 10,000 births. The infant mortality rate was 48 per 1,000 live births. These are the lowest maternal and infant mortality rates on record for the United States. (The record covers the years 1915-39.) The maternal mortality for 1939 was 9 per cent lower than that for 1938 and 32 per cent lower than that for 1934 (the year before the passage of the Society Security Act). The infant mortality rate for 1939 was 6 per cent lower than that for 1938 and 20 per cent lower than that for 1934.

The maternal mortality rates for the States vary widely. Seven States had rates of less than 30 per 10,000 live births; 22 had rates of 30 to 39; 8, 40 to 49; and 12 had rates of 50 or higher. The States with the highest rates were Florida (65) and Louisiana (62). The States with the lowest were Idaho (22), North Dakota (24), Oregon (24) and Connecticut (26). The rate of Idaho is the lowest rate recorded for any State.

The infant mortality rates of the States varied widely. Oregon set a new all-time low record for States (35); two States, Connecticut and Minnesota, had rates of 36.

Child, February, 1941.



JAMES DOUGLAS GOLD
President
Connecticut State Medical Society
1941 —

MESSAGE FROM THE PRESIDENT

Connecticut State Medical Society

ON ASSUMING the office of President of the Connecticut State Medical Society, I bring you greetings for the coming year. Despite the difficulties, foreign and domestic, which we are facing, I believe these should be real greetings, inspired by optimism and clothed in the language of hope and cheerfulness.

For in these times of stress, with war clouds just at the horizon and a federal jury finding our parent, the American Medical Association, guilty of "a criminal conspiracy to restrain trade," we need optimism to balance the propaganda of despair which is now so widely accepted. If the public interest, if ethical and scientific standards are to be maintained and an element of independence preserved for the medical profession, we must be watchful, vigilant and alert, for socialized medicine is just around the corner, camouflaged by reformers as the panacea for all the ills which beset those who belong to the low income group. Organized medicine has long since satisfied itself that this innovation is simply another proof of the saying that "Movement and progress are not synonymous."

As the year of 1942 approaches, we must remember that our State Medical Society then reaches its one hundred and fiftieth anniversary. Preparations for the sesquicentennial celebration are well formulated and to make that a success your enthusiastic support is solicited. Begin thinking about it now and send me your suggestions. They will be given careful consideration.

The great and honored men of our profession who have gone on before us have established a standard which we must strive now and in the future to maintain. We must preserve this priceless heritage so that our professional descendants may receive it as humbly and carry it as proudly as we have. Let us sustain our noble traditions and deserve the respect of those who follow us.

We must be gratified at the realization of a long-cherished dream—I refer to the establishment of a full-time personnel in the office of the Society. This service means much to each of you, for it is your Society and your interests which are safeguarded by the watchfulness of this office.

We shall face this coming year with courage, hopeful that it will be filled with achievements worthy of our rich endowment of professional skill. Let us particularly keep mindful of our country's rising problems and prepare ourselves as citizens and physicians to contribute a generous share to their solution.

James Douglas Gold, M.D.

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NEWS: Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physi-

cians. We shall be glad to know the name of the sender in every instance.

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EDITORIALS

Were You There?

The 149th Annual Meeting of the Connecticut State Medical Society has passed into history, making way for the Sesquicentennial in 1942. Each successive annual meeting gives an impression of being more successful than its predecessors. The Bridgeport sessions just closed were no exception. With a registration of approximately 700 we may congratulate ourselves as a Society which is progressive, alert, and eager to find the truth. The membership today is the largest in our history, 1825, but as usual there were many so busy, so filled with inertia, or so indifferent to the vital issues medicine is facing today that they stayed away.

A new note in the annual meeting was sounded by the introduction of the timely problems of medical defense and industrial medicine. The spirit of friendship was enhanced by the presence of several guests from neighboring states. The Council displayed its progressive spirit by passing an amendment to our by-laws creating an associate membership for leaders in fields of science closely related to medicine.

Doctor Ogilby, President of Trinity College,

sounded a note of challenge to all when in his address at the annual dinner he reminded us that the air is vibrant with lies and that it is of paramount importance to keep education a going concern so that there will be someone to carry on the spirit of truth and the principles of democracy.

A Real Honor

By appointing Doctor George M. Smith to the State Defense Council Governor Hurley has seen fit to honor organized medicine in Connecticut. This honor is appreciated, not alone by the recipient, but by all of the physicians in the State. It serves to remind us of the very cordial relationship existing between the Chief Executive of our State and the medical profession, but it also affords us another opportunity to serve in a time of emergency when professional medical advice is of inestimable value.

To Doctor George M. Smith we extend our hearty congratulations. By his continuous and untiring efforts on behalf of medical defense he has demonstrated his outstanding ability as the logical representative of the medical profession. His judg-

ment always has been wise and in his new capacity as a member of the State Defense Council we have assurance of real leadership in the affairs of State.

The Foreign Graduate

For the past five years the Medical Society of the State of Illinois has tried to solve the difficult problem of licensure of graduates of foreign medical schools.

For the past year this problem has apparently been brought to complete solution by the acceptance by the Director of Registration and Education for the State of Illinois, of a resolution, which, in effect, prohibits foreign graduates, whether citizens or non-citizens from practising in the State of Illinois.

In January 1939, the Medical Examining Committee of the Illinois State Medical Society recommended to the Department of Registration and Education a rule to the effect that the recognition of all medical colleges located outside the United States be withdrawn by the Department of Registration and Education of the State. The foreign medical colleges, however, could apply for recognition at any time and recognition given if a satisfactory personal investigation was made of the college by the Committee appointed by the Director of the Department of Registration and Education. This recommendation, however, was not accepted by the Department at that time, but has been found acceptable this year. The Council of the Illinois State Medical Society gave the usual reason for its stand; that is, the raising of requirements of licensure in order to provide the best medical care available, and pointed out that, whereas a determination of the reputability and good standing of the medical schools in the United States is on a sound basis by reason of periodic inspection of such schools by the Council of Medical Education and Hospitals of the American Medical Association, yet the Department has available no comparable evidence with respect to medical schools located elsewhere because of the fact that no agency exists in this country for inspection or classification of such foreign schools. Despite the lack of authentic information as to the quality of instruction given in foreign schools, graduates from such schools are increasing in number in Illinois, as evidenced by the study of a table of foreign graduates licensed between 1931 and 1940. This shows that in 1931 the State of Illinois licensed nine graduates of foreign schools, whereas in 1940 the number of foreign graduates licensed was 116. For

the next year the State of Illinois has a total of 160 incomplete applications from foreign graduates.

The Illinois State Medical Society, while it admits the physical impossibility of determining the standard of foreign medical schools, requires that the admittedly impossible be done before graduates of foreign schools be admitted to practice. It would appear to us that this imposes an undue hardship on many reputable and desirable doctors who have trained in foreign schools. As long as it is so difficult to appraise foreign schools it would seem that the fair thing to do at this time would be to lay the stress of admission on the examination of the candidate both as to character and professional ability. Insistence that the candidate be a citizen of the United States, a matter previously discussed in this Journal,* while perhaps something of a hardship because of the residency requirements, seems entirely justified. Interference with the right of a citizen of the United States to practise his chosen profession because he trained in a foreign school would seem both unjustified and unfair.

* Jour. Conn. State Med. Soc., III, 300.

Commendation Appreciated

Many have been the favorable comments received since the appearance of the March number of the *Journal* with its new cover, type and format. These letters of congratulations have been written, not alone by members of our own State Medical Society, but by some of our readers scattered over the United States. We take pleasure in quoting the following which appeared in the editorial columns of *Medical Annals* of the District of Columbia, April 1941:

"A number of state medical journals come across the desk of the editors of the *MEDICAL ANNALS* and it is natural that comparisons should be made as to content and appearance. One fact stands out and that is that there has been general improvement in all of these journals. It is also apparent that their editors have come to realize that their journals must compete for reader interest with numerous medical and lay publications (see "Change Comes to State Medical Journals," *Medical Annals of the District of Columbia*, March 1940).

"An example of progressive editorship is the *Connecticut State Medical Journal*. The *Journal* is not only carefully edited but from the standpoint of typography and format it is most inviting to the reader. Editors of the *ANNALS* extend their congratulations."

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

NEW HAVEN

New Members Elected to the Society at the Annual Meetings of the County Associations In April, 1941

FAIRFIELD COUNTY

Raymond F. Bellew, Bridgeport
Hyman D. Brier, Bridgeport
Eugene D. Brochu, Bethel
William T. Clark, Bridgeport
George R. Cody, South Norwalk
Paul P. Duzmati, Bridgeport
Maxon H. Eddy, Bridgeport
Edwin D. Flanagan, Norwalk
Samuel Friedman, Newtown
Howard H. Green, South Norwalk
Kenneth L. Grevatt, Redding
Rufus W. Hall, Bridgeport
George W. Hebard, New Canaan
Weston M. Kelsey, Westport
Robert E. Kennedy, Newtown
Raymond A. Martin, Bridgeport
Jane E. Oltman, Newtown
Joseph J. Pagliaro, Shelton
George K. Pratt, Westport
Katharine S. Quinn, Bridgeport
Lee R. Reid, Shelton
Gregory N. Rochlin, Newtown
Leo M. Smith, Stamford
Eric Twachtman, New Canaan
R. Edward Vioni, Bridgeport

HARTFORD COUNTY

Harry Gillespie, Hartford
Myer Goldschmidt, New Britain
Walter Grossman, Hartford
James Gudger, Hartford
Curtiss B. Hickcox, Hartford
Eugene E. Lamoureux, Hartford
M. Vincent Mikolainis, Hartford
Enos J. O'Connell, Unionville
Sidney Sewall, Elmwood

LITCHFIELD COUNTY

Gilbert R. Hubert, Torrington

The total membership of the Society is now 1825, the largest it has ever been.

MIDDLESEX COUNTY

Willard E. Buckley, Middletown
Eugene F. Callender, Chester
Nelson L. Deming, Saybrook
Alexander J. Mozzier, Middletown

NEW HAVEN COUNTY

Louis J. Aiello, New Haven
Justin L. Cashman, North Haven
Theodore R. Dayton, Wallingford
Robert L. DuBois, Waterbury
Bruno Gerstl, New Haven
Margaret C-L. Gildea, New Haven
Milton S. Godfried, New Haven
Samuel J. Goldberg, Jr., New Haven
Morris A. Granoff, New Haven
Vincent J. Grillo, Hamden
Edward R. Harvey, Seymour
Martin Heinemann, New Haven
Irving Katz, Meriden
John R. Lee, Devon
Edward S. Lewicki, Waterbury
Elliot R. Mayo, Waterbury
Frank J. McGuire, Guilford
Herbert C. Miller, Jr., New Haven
Joseph S. Riccio, Hamden
Alan A. Rozen, New Haven
John T. Spignesi, Wallingford
Charles G. Stetson, Milford
Arthur G. Wilkinson, New Haven
Dwight E. Wilson, New Haven
Philip D. Woodbridge, New Haven

NEW LONDON COUNTY

Frederick B. Dart, Niantic
Roger N. Fowler, Mystic
Roger N. Ryley, Mystic
Philip J. Savage, New London
Francis C. White, Norwich

TOLLAND COUNTY

Wendelin G. Luckner, Stafford Springs

WINDHAM COUNTY

Moses Margolick, Putnam

Transfers

FAIRFIELD COUNTY

Irving B. Akerson, Bridgeport

NEW LONDON COUNTY

William A. Bryan, Norwich
Joyce S. Morris, New London

Reinstatement

NEW HAVEN COUNTY

William L. Sheahan, New Haven

County Association Officers 1941-42

FAIRFIELD

President: Ralph W. Crane, 50 Glenbrook Rd., Stamford
 Vice-President: Charles H. Sprague, 29 Hanover St., Bridgeport
 Secretary: J. Grady Booe, 144 Golden Hill St., Bridgeport
 Treasurer: Clifton C. Taylor, 881 Lafayette St., Bridgeport
 Councilor: Samuel F. Mullins, 116 Main St., Danbury

HARTFORD

President: Thacher W. Worthen, 179 Allyn St., Hartford
 Vice-President: William R. Hanrahan, 209 Center St., Bristol
 Secretary-Treasurer: Frank T. Oberg, 50 Farmington Ave., Hartford
 Councilor: Arthur B. Landry, 50 Farmington Ave., Hartford

LITCHFIELD

President: Herbert C. Oelschlegel, 19 Maiden Lane, Torrington
 Vice-President: Robert C. Sellew, Sr., West Main St., No. Canaan
 Secretary-Treasurer: W. Bradford Walker, Cornwall
 Councilor: Charles A. Turkington, On the Green, Litchfield

MIDDLESEX

President: Harry S. Frank, 144 Washington St., Middletown
 Vice-President: Edgar Fauver, 55 Vernon St., Middletown
 Secretary: Charles Russman, Box 361, Middletown
 Councilor: Alfred Sweet, 50 Crescent St., Middletown

NEW HAVEN

President: Frederick N. Sperry, 107 Whitney Ave., New Haven
 Vice-President: William J. H. Fischer, 3 Lafayette St., Milford
 Secretary: Ralph E. McDonnell, 158 Whitney Ave., New Haven
 Councilor: Thomas P. Murdock, 147 W. Main St., Meriden

NEW LONDON

President: Hugh F. Lena, 154 Broad St., New London
 Vice-President: Robert G. Urquhart, Uncas-on-Thames, Norwich
 Secretary: Thomas Soltz, 26 Main St., New London
 Treasurer: Solam Segel, 257 Main St., Norwich
 Councilor: George H. Gildersleeve, 310 Main St., Norwich

TOLLAND

President: Walter C. Haviland, Mansfield Depot
 Vice-President: Donald M. Beckwith, 68 Prospect St., Rockville
 Secretary: Francis H. Burke, 27 Park St., Rockville
 Councilor: Charles T. LaMoore, Mansfield Depot

WINDHAM

President: Morton H. Chapnick, 168 Main St., Putnam
 Vice-President: Arthur D. Marsh, Hampton
 Secretary: Ralph L. Gilman, University of Connecticut, Storrs
 Councilor: Robert C. Paine, Thompson

Committee Meetings

Many of the Society's committees have met recently for the transaction of routine and special business.

Narcotic Drug Addiction, at Elmcrest Manor, Portland, as guests of Carl Wagner, April 17.

Sesquicentennial Planning Committee, Graduates' Club, New Haven, April 30.

Crippled Children's Advisory Committee at the office of the State Health Commissioner, Hartford, May 5.

The Editorial Board of the Journal at Willimantic as guests of Edward Ottenheimer, May 8.

Public Health Committee, Society's Office, May 8.

Advisory Committee on Evaluation Study of Serological Laboratories, Society's Office, May 8.

Hospital Committee, Society's Office, May 9.

The Council

The regular monthly meeting of the Council was held at the Society's office on May 12. All members of the Council were present. Routine and special matters were considered and recommendations to the House of Delegates were prepared.

THE MURRAY BILL

A bill to amend the National Selective Service Act S. 783, the "Murray Bill" was discussed at some length and the regulation with respect to deferment and exemption of medical students, internes and physicians which has recently been issued Selective Service Headquarters was considered. (The regulation is published in the Medical Preparedness Section of this Journal.) The Council voted that the Society be recorded as opposed to the bill now before the Congress of the United States in the belief that the desired ends may be accomplished by appropriate regulations without changing existing law.

SESQUICENTENNIAL CELEBRATION EXPENSES

The Council voted to appropriate the sum of two thousand dollars from the Annual Meeting surplus to pay the expenses of the 1942 celebration exclusive of the publication expenses. This sum is to come from the accumulated surplus derived from the commercial exhibits in the past five years and is not to be withdrawn from the general funds of the Society.

ADVISORY COMMITTEES TO THE COMMITTEE ON MEDICAL PREPAREDNESS

The Council authorized the Medical Preparedness Committee to establish advisory committees in

special fields to assist the Committee in the preparation of its program for disaster relief and civilian medical care. It is contemplated that advisory committees in pediatrics and maternal welfare will be needed at once.

EVALUATION STUDIES OF SEROLOGICAL LABORATORIES

The Council voted to support a request from the State Health Commission for an added appropriation to repeat and extend the study of serological laboratories that was jointly undertaken by the Health Department and this Society in 1940.

Connecticut At the A. M. A. In Cleveland

Several Connecticut physicians will participate in the program for the Annual Meeting of the American Medical Association in Cleveland this month. Doctor John Fulton, New Haven, will present a lantern demonstration of the Cerebral Function in Aviation before the Section on Pathology and Physiology. Doctor Denis S. O'Connor of New Haven, with Doctor Roland Hammond of Providence will make a presentation on Occult Fractures before the Section on Orthopedic Surgery. Doctor Ashley W. Oughterson will open the discussion with a paper on Carcinoma of the Stomach with Doctor Frederick F. Boyce of New Orleans before the Section on Surgery. Doctor Maurice Pike, Hartford, will serve as a demonstrator in the Special Exhibit on Lane Backs that will be produced by a group of prominent orthopedists. Doctor Herbert Thoms, New Haven, and Doctor William W. Greulich of Western Reserve University School of Medicine, will present an exhibit showing the Growth and Development of the Female Pelvis During Puberty and Early Adolescence. Doctor Ralph Tovell, Hartford, and Doctor Joseph E. Remlinger, Hartford, have a paper on the History and Present Status of Oxygen Therapy and Resuscitation before the Section on Anesthesiology. Doctor James D. Trask, New Haven, will present a lantern demonstration on Epidemiology in the Panel Discussion on Poliomyelitis before the General Scientific Section. Doctor Charles C. Wilson, Hartford, presents the introductory statement in the Symposium on School and Environment in Relation to Health and a paper on School Health Policies before the Joint Meeting of the Sections on Pediatrics and Public Health.

Study of Neonatal Deaths and Stillbirths

The State Department of Health and the State Medical Society have a combined interest in determining what factors may be responsible for neonatal deaths and stillbirths. The Public Health Committee of the State Medical Society has recommended that certain supplementary data be requested of physicians on the following certificates:

- 1) Live birth certificates revised as of January 1, 1940.
- 2) Death certificates of all infants dying under one month of age.
- 3) Stillbirth certificates revised and now at the printers. (These include a supplement which will be mailed directly to the State Department of Health in the envelope supplied.)

In the analysis of the material, no attempt is made to study individual cases, so that physicians should feel free to report completely knowing that they are not discussing personal information. Although reporting on the certificates is fairly complete, physicians are urged to cooperate by reporting every item and to write "no" or "none" whenever a negative answer is signified. An item checked with a dash has to be considered as not reported.

Health Supplement to Wisconsin Medical Journal

The January 1941 number of the *Wisconsin Medical Journal* carries a supplement entitled Health Achievements in Wisconsin. By means of charts, pictures, and short printed facts the State Medical Society of Wisconsin has placed before the readers of the *Journal* some of their health achievements, the importance, extent and value of medical education and training, and the problems on which medicine is now working. This supplement is very striking as well as interesting.

During 1940 there were 5,879 actual additions to the medical profession in the United States, its territories and possessions, the thirty ninth annual compilation of medical licensure statistics by the Council on Medical Education and Hospitals of the American Medical Association reveals in the report published recently.

THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

Bristol Hospital

A medical defense organization for a complete setup with the city authorities and the Hospital coöperating is well under way.

Greenwich Hospital

MEDICAL DEFENSE PLANS

The Board of Directors of The Greenwich Hospital Association have adopted the following procedure to be employed during a major emergency:

- (1) Transportation of wounded to be undertaken by the Red Cross with the use of the Police Ambulance, two private ambulances, and, if necessary, Stamford and Port Chester. Only one interne will be provided from the Greenwich Hospital to go with the Police Ambulance.
- (2) If during the daytime, the immediate dismissal of all patients from the Dispensary.
- (3) All wounded and casualties to be brought to to the Emergency Room of the hospital, or to the Dispensary for clearing.
- (4) Clearing to be accomplished by transfer to the Operating Room of seriously injured, or to the Nurses Home if facilities are not available in the main hospital.
- (5) In the event of a large number of casualties, the Nurses Home will be made available by the use of the ground floor. This space could be converted by help from the Red Cross or Boy Scouts to aid in the necessary removal of furniture and the installation of beds in the space available.
- (6) Notification of all Assistant Attending Physicians and Surgeons of the Staff to be present in the Dispensary and Emergency Room to help in the classification and clearing of the injured.
- (7) Notification to the Town Nursing Service to be prepared if necessary to supply additional nurses to help in clearing or caring for the wounded.

RED CROSS VOLUNTEER AIDE COURSE

Purpose

To train a corps of women to serve as volunteer aides to nurses in hospital, clinics, and health organizations, as a contribution to assist Red Cross nurses in disaster or other emergency.

Conduction of Course

Course conducted by graduate nurse authorized by the Red Cross.

Hours of Class Room instruction—60.

Hours of practice in care of convalescent patients in the hospital—40.

Authorized Duties of Volunteer Aides

1. Make beds and keep environment of patient neat.
2. Care and assembling of non sterile equipment.
3. Give care to convalescent patients in hospital, as follows:

Baths and evening care.

Prepare patients for meals, carry trays and feed helpless patients.

Help with admission and discharge of patients. Get patients up in chairs.

Take patients to and from treatment rooms.

NURSING

While graduation exercises are being held in September, the administration is contemplating a larger class of new students, providing adequate living accommodations can be arranged.

Griffin Hospital, Derby

MEDICAL DEFENSE PROGRAM

The Health Officers of four towns are working with the medical group, city officials, and defense groups on the program. According to the plan, First Aid Stations will be established, and doctors, nurses and aides assigned there. The arrangements will be made for transportation of patients to the hospital from these stations.

In the Griffin Hospital we have checked and listed all available spaces where extra beds and cots may be

placed; listed all available beds to set up; put aside extra linen and bedding, checked and put aside extra equipment, surgical dressings, etc., in a store room; listed all Private Duty nurses and married nurses who will be available for emergency call.

The "Gray Ladies" (Red Cross) and members of the Hospital Aid Society are making surgical supplies and will serve as aides in the hospital in an emergency.

An emergency Blood Donor Service is being made up from members of the various clubs, organizations, and Scout leaders in the communities.

The hospital laboratory is typing and listing all volunteers.

Several First Aid Classes are being conducted at the hospital and in the community for graduate nurses, hospital employees and interested persons in the community.

Lawrence and Memorial Associated Hospitals, Inc., New London

MEDICAL DEFENSE PROGRAM

Preparations for disaster emergencies have been under way in New London and vicinity for some time. The entire field of preparedness is being covered, with various agencies collaborating, such as the Medical Society, American Red Cross, Council of Social Agencies, the hospitals, nurses, etc., etc. Details of the preparations are, of course, too numerous to outline. In brief, they include medical service, nursing service, hospital facilities, transportation, housing, utilities and food and clothing.

The Lawrence and Memorial Associated Hospitals' program includes preparations to accommodate 50 to 75 emergency patients, involving all the necessary items of equipment, extra supplies, etc. On February 4, we inaugurated a Refresher Course for older or inactive graduate nurses of the community and 36 have so far enrolled. From this group we would expect to obtain the necessary extra nurses to take care of a large number of emergency patients. We are preparing an extra emergency receiving room and extra emergency wards. One major problem so far unsolved is that of obtaining suitable beds. It is hoped that help may be forthcoming from some state or governmental agency.

NURSING SERVICE

The administration is tentatively planning to accept the regular September class in July this year in order to meet the emergency created by a short-

age of nurses. Consideration is also being given to entering an extra class in February 1942.

INTERNES

The problem of securing internes is most acute in the smaller hospitals and, in an attempt to meet this condition, the Lawrence and Memorial are lengthening the interne service to a two year period at the same time amplifying the teaching program and making improvements in the living quarters.

The Litchfield County Hospital, Winsted

MEDICAL DEFENSE PROGRAM

Herbert Morford, Superintendent, writes as follows:

"Just across the road from the Hospital there is The Gilbert Home, an institution for the care of dependent children. As they do not have a large census at this time, we have arranged for them to provide beds for 50 patients in case of an emergency. We have planned to use that institution as an evacuation center and after taking the patients, admitting the more serious ones to the Hospital.

"We have called on the Winsted Nurses Association to hold themselves in readiness for immediate service so that we should have an adequate number of registered nurses. We believe that our Medical and Surgical Staffs are adequate."

Middlesex Hospital, Middletown

MEDICAL DEFENSE PROGRAM

This community which formerly had several groups organized in individual defense programs, has now coördinated them all under the chairmanship of Mr. Clemens Mortenson, under the auspices of the American Red Cross. Every interested group in the community is taking part covering first aid, nursing service, hospitalization, housing, traffic problems, transportation, public health, communications, policing and many other groups.

But one meeting has been called of the coördinated committee and all groups are working on plans for complete organization of this committee. Another meeting will be held soon in which these plans will be studied in detail for effective operation.

The Hospital's part in the defense program has been to organize a 30 bed unit, complete in all its detail, and an additional 18 bed unit will be organized as soon as the funds are available. This includes beds, mattresses, medical and surgical supplies and certain makeshift arrangements. One of the make-

shift arrangements is the substitute for a bedside table. For this, 18 inch squares of oilcloth have been cut and are put across the seat of a straight chair and thumb tacked on the under side. All equipment is inventoried and stored in available places. The last major detail which is as yet unsolved is an auxiliary power unit for emergency needs. At the present time, we do have an extra power line with an automatic switch.

NURSING SERVICE

The administration is planning on taking in a larger class in September in order to meet the emergency created by the shortage of graduate nurses.

A new bacteriological laboratory to meet the present day requirements of nursing education is also being considered.

INTERNES

In order to secure adequate interne service, the administration is planning to have a senior interne who will perform duties similar to those of a mixed residency and to increase the service from one to a two year period.

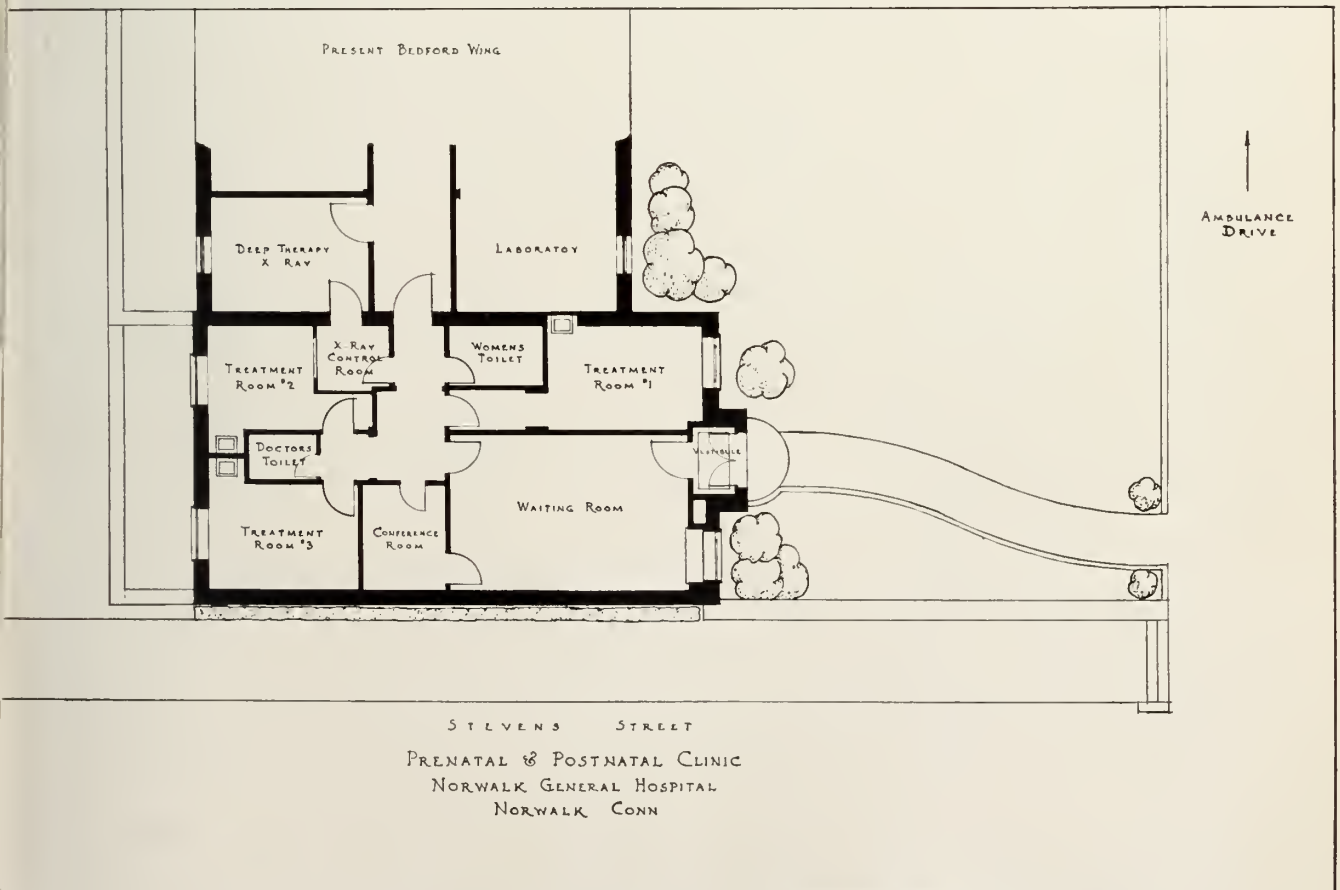
NEW EQUIPMENT

Two auxiliary operating room lights and one major operating room light have been purchased with funds provided through an exhibition golf match sponsored by the doctors in the fall of 1940.

NOTE: Mr. Pfirman's article in the last issue of *Hospitals* is of real interest and should be read by every executive.

In addition, it's fine to have members of our Association supply articles for these national publications.

Norwalk General Hospital



The new prenatal and postnatal clinic of the Norwalk Hospital which was dedicated May 12

The Tumor Conferences which have been in existence for five years will also be carried on in this clinic addition.

The cost of construction, approximately \$15,000, was donated by the Bedford Fund. The existing clinics in Norwalk and South Norwalk will be

merged and their work carried on in these new quarters.

OUTLINE OF HOSPITAL ORGANIZATION TO CARE FOR A MAJOR DISASTER IN NORWALK OR ADJACENT AREAS OF FAIRFIELD COUNTY

In the event of such a disaster, the Superintendent or Acting Superintendent to be notified by Col. Anson Keeler or his representative. The following steps will then be taken:

1. Surgical Teams Nos. 1 and 2, as previously organized by the Staff, will be called and sent to the scene of the disaster to render such service there as may be possible.

2. The Superintendent, and all Department Heads of the hospital, to be notified and to report immediately for duty regardless of the hour, in the event that they are not within the building.

3. The Superintendent, in consultation with Col. Anson Keeler, will hold himself in readiness to set up an emergency hospital in the Norwalk Armory or the gymnasium of the Norwalk Y. M. C. A., of such size as may be necessary according to the extent of the disaster in the event that it is certain that more than twenty patients must be hospitalized.

4. In the event of such a decision the Department of Nursing (Miss Marguerite C. Holmes, Director) will be notified. She will have previously organized from her staff of approximately 55 graduate nurses, 75 students and 10 attendants, an emergency hospital organization which will promptly report for duty at the location selected. This unit will be adequately organized and will be in charge of the Assistant Superintendent of Nurses. Each member of it will assume similar duties to those in the Norwalk Hospital, according to training and experience.

5. Two of the hospital staff of five interns who can best be spared will accompany this unit to the emergency hospital.

Transportation will be provided by hospital employees whose cars are available. There are always twelve or more cars of that description at the hospital.

6. In the event that an emergency hospital is established, the Maintenance Department will discontinue all except emergency work and under the direction of Mr. C. L. Lawrence, Engineer, will report to the emergency hospital to render such assistance as may be required. Likewise half of the porters and maids in the Housekeeping Department,

with the Housekeeper, will report to the emergency hospital for duty there.

7. The same procedure will be followed by the Dietary Department which will be charged with the duty of setting up an emergency kitchen at the emergency hospital so that adequate food service may be maintained. Such employees, including the chef, as can be relieved from hospital duty, will report according to the prearranged plan at the emergency hospital and with the assistance of such other volunteers as may be available will organize and maintain an emergency Dietary Department.

Other employees of the hospital will likewise be designated by the Superintendent to assist at the emergency hospital as the need develops.

8. The Surgical Teams at the scene of the disaster will call for such additional help and supplies as they may require through a message to the Superintendent of the hospital, who will relay the call to such other members of the staff as may be needed.

9. The decision to establish an emergency hospital will be conveyed by the Superintendent to the heads of the Departments of Medicine and Surgery who will request such members of the Staff to function there as seem to be necessary.

Waterbury Hospital

MEDICAL DEFENSE PROGRAM

The local committee has developed the following plan:

The city is divided into four zones each containing about the same number of manufacturing industries and having approximately the same acreage and population. Each zone also has established a central treatment station completely equipped to care for every type of casualty and staffed with doctors and nurses.

Provision has been made to evacuate approximately one hundred patients from each of the two hospitals if and when necessary.

Arrangements have been made for 122 vehicles to transport patients from the hospitals and to bring victims of a disaster to the hospitals.

At the hospitals, the staff physicians have arranged to list in the admitting office each day the names of patients who might be evacuated in case of an emergency. Members of the Hospital Aid will report promptly to the hospital in order to help with the discharge of patients and the reception of the injured.

Four operating teams have been appointed from the staffs of each hospital and they, too, will report for immediate service.

The hospitals are also collecting blood serum for emergency use.

In event the disaster is so great the two hospitals cannot care for all the injured, the overflow will be cared for in other available quarters. When a disaster occurs, the telephone will immediately call doctors, transportation units, nurses and others, all of whom have been listed.

NOTE: Space will not permit the printing of all the details of the Waterbury plan which has been multigraphed and placed in the hands of all responsible persons connected with it. However, it is most complete, giving details of police and fire department service with their equipment, the use of tags for identification.

It lists provision for service in event of extensive bombing giving data as to temporary shelter, food supply, water, etc.

Connecticut Tuberculosis Association Conference

The following is the program of the Sixth Regional Conference On Local Program Planning sponsored by the Connecticut Tuberculosis Association which was held on Thursday, April 24, 1941, at 2:30 P. M. in the auditorium of the Charlotte Hungerford Hospital.

Remarks by the Chairman

Mabel Baird, Campaign Director Connecticut Tuberculosis Association

Greetings from the Director

Doctor Albert W. Buck, Director, Charlotte Hungerford Hospital, Torrington

The State's Program of Case-Finding

Doctor Paul S. Phelps, Director of Case-Finding, State Tuberculosis Commission, Hartford

How New London made a Self-Appraisal of its Tuberculosis Activities

Miss Gertrude Osborne, R.N., Supervisor,
New London Visiting Nurse Association

General Discussion

Thirty-two nurses and Board members from the following municipalities attended the meeting; Hartford, Washington, New Preston, New Milford, Woodbury, Norfolk, New London, Bristol, Waterbury, Cornwall and Torrington.

Charlotte Hungerford Hospital Auxiliary

On Thursday, May 15, at the Conley Inn the Charlotte Hungerford Hospital Auxiliary held its annual dinner in commemoration of the birth of Charlotte Austin Hungerford. The president, Mrs. Charles E. Bennett, presided and after the Invocation by the Rev. Carl Key introduced the toastmaster Mr. Henry G. Ellis.

Remarks by President Francis H. Griffiths and Director Albert W. Buck of the Charlotte Hungerford Hospital followed.

The speaker of the evening was Mr. Robert Deming of New Haven, Supervisor of the State Board of Adult Education, who chose as his subject "Is Character Contagious." The Benediction was by Rev. James Egan. The Committee of arrangements was under the chairmanship of Mrs. William Whitfield, other members being Mrs. Edward Mackintosh, Mrs. Gustave Broberg, Mrs. W. A. Gleeson, Mrs. William Mulcunry, Mrs. Emil Pulver, Mrs. Alfred Lautier, Mrs. Will Griswold and Mrs. Raymond Bentley.

The annual meeting for the election of officers of the Charlotte Hungerford Hospital Auxiliary was held on May 20 in the auditorium of the Hospital.

The average age at death of physicians in the United States in 1940 was 66.3 as compared with 66.1 in 1939. Heart disease again was shown to be the leading cause of death.

THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the \$37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation, but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.

(SEE PAGE 2)

MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic

GEORGE M. SMITH, M.D., State Chairman, 258 Church Street, New Haven, Conn.

State Chairman on Medical Preparedness Appointed to State Defense Council

Governor Hurley has appointed Doctor George M. Smith, Pine Orchard, Chairman of the Society's Committee On Medical Preparedness, to be a member of the State Defense Council.

The entire Council is as follows:

Governor Hurley, chairman; Colonel Samuel H. Fisher, state defense administrator, vice-chairman, both ex-officio; William M. Maltbie, chief justice of the Supreme Court of Errors; General Sanford H. Wadhams, chairman of the State Water Commission; State Police Commissioner Edward J. Hickey; Adjutant General R. B. DeLacour; E. Kent Hubbard, president of the Manufacturers Association of Connecticut; James J. Clerkin, president, Connecticut Federation of Labor; A. F. Brooks, New Haven, vice-president, Southern New England Telephone Company; James Lee Loomis, trustee of the New York, New Haven and Hartford Railroad; Mrs. Dorothy S. Bowles, Essex, former president of the Junior League of America; Doctor George Smith, Pine Orchard; Samul H. Graham, Suffield, president, State Farm Bureau; and Charles L. Campbell, Hartford, president, Connecticut Light & Power Co.

The first meeting of the Council was held on May 12.

Connecticut Physicians Ordered to Active Duty

- John M. Cotton, Hartford.
- *John S. M. Hamilton, Stamford.
- Hilton D. Haines, Greenwich.
- *Justin L. Cushman, North Haven.
- *James K. Knepp, Bridgeport.
- *Harry B. Miller, New Britain.
- *Louis Newton, Bridgeport.
- *Anthony Nevulis, New Britain.
- *Brae Rafferty, Willimantic.
- *William M. Rynard, Stamford.
- Joseph Sklaver, Waterbury.
- *George I. Sneiderman, Hartford.
- *George L. Tunick, Greenwich.
- *Leo L. Tylec, Union City.
- *Members Connecticut State Medical Society.

Changes In Selective Service Organization

Board 14A

Walter J. Reilly, Naugatuck, added as alternate examiner.

Board 14B

William J. German, Woodbridge, added as alternate examiner.

Board 15B

Thomas Cottiero, Waterbury, to be chief examiner to succeed Walter L. Barber, resigned.
Sidney W. Jennes, Waterbury, added as alternate examiner.

Board 22B

Frary Hale, Bridgeport, to be chief examiner to succeed Irving L. Nettleton, resigned.
Maxon H. Eddy, Bridgeport, added as alternate examiner.
Andrew J. Panaterri, Bridgeport, added as alternate examiner.

Physical Fitness of College Seniors for National Defense

ORVILLE F. ROGERS, M.D., *Director, Department of University Health, Yale University*

In view of the interest in the probable result of the physical examination of the men registered under the Selective Service Act a review was made of the records of a group of senior students in Yale College, the Sheffield Scientific School, and the School of Engineering. In the three Schools there are 716 seniors and the physical examination and clinical

records of 350, approximately one half, were studied. The records are filed alphabetically, not by Schools, and the records starting at the beginning of the alphabet were taken consecutively from the files until 350 had been studied. All of these records included at least three, and a great majority of them four, physical examinations. Notes on all illnesses or injuries for which advice or treatment at this office had been sought by the student are included in the student's record and were consulted in reviewing his physical status.

Of the 350 men studied 256 were placed in Class 1-A, as fit for general military service, 78 in Class 1-B, as qualified for limited military service, and 16 in Class 4-F as totally and permanently disqualified for military service. The appended table gives the percentage of these figures to the whole group, and the reasons why those who were regarded as unfit for general military service were so classified.

TOTAL EXAMINED	CLASSIFICATION		
	1-A	1-B	4-F
350	256	78	16
100%	73.1%	22.3%	4.6%

CONDITIONS FOUND	CLASSIFICATION	
	1-B	4-F
Visual defects	53	0
Impaired hearing and chronic ear diseases	2	1
Chronic diseases of the nose or accessory sinuses	1	2
Heart disease, congenital or acquired, or severe functional disturbance	0	5
Deformities or injuries to bones and joints	7	1
Overweight	2	0
Underweight	5	1
Over height	0	1
Allergic conditions	5	1
Bronchiectasis	1	0
Peptic ulcer	0	1
Chronic phlebitis	0	1
Testicle in inguinal canal	1	0
Loss of one kidney	1	0
Emotional disturbance	0	2

The outstanding fact in this survey was the large number of men whose vision in one or both eyes did not come up to 20/100 without lenses, the minimum for Class 1-A. Only a very few who could read 20/100 without glasses were disqualified because their vision could not be brought up to 20/40 with lenses. These 53 men with vision below the minimum requirement for Class 1-A constituted 68% of the

assignments to Class 1-B, and amounted to 15% of the entire group of 350. No figures seem yet to be available from the local boards to enable one to make a comparison of this finding with the actual result in the general population. That it would be greater in the student population was to be expected, as previous studies have shown that the increase in visual defects during the four years in college exceeds that in the same age level outside of college. It is, nevertheless surprising that this one factor is so preponderant.

Another interesting fact is that no one of the group failed to meet the minimum dental requirements. One or two were close to the line but will be included in Class 1-A unless further loss of teeth has occurred before their examination by the local board.

There can be no doubt but what this survey is open to question on the point that many of the decisions were matters of judgment and they may be reversed in actual practice. In addition to this many findings were borderline and at a subsequent examination the findings might be sufficiently different to dictate a different classification. It is also quite probable that our four year history would give us a clearer picture of the individual's capability as a soldier than could be obtained on a single examination. In certain doubtful cases the decision not to place a student in Class 1-A may have been colored by this background of information, though an effort was made to classify on the basis of objective findings at the most recent physical examination. However, unless all the errors have been made in one direction the chances favor reasonable equalization, and it may be assumed that the figures represent a fair approximation to what is to be expected from the physical classification of college students under the present Selective Service regulations.

Deferment of Physicians and Medical Students in the Selective Service

A report from the Office of Production Management to the Deputy Director of Selective Service conclusively demonstrates that the medical profession constitutes an activity essential to the national health, safety and interest, and that a serious interruption or delay therein is likely to impede the national defense program. The substance of this report is broken down in detail as follows:

At present it is estimated that there are approximately 155,000 practicing physicians in the country.

The national defense program as now outlined will require 7,900 physicians for the Army, 900 for the Navy, 100 for the Public Health Service and 100 for the Veterans Administration, a total of 9,000 medical doctors, in addition to present staffs. This represents a reduction of at least 5% in the number of doctors available for service in civilian life. Such a reduction imposes an added burden on physicians serving the general public. The expanding defense program greatly increases industrial hazards to workers and will increase the demand for medical care in the field of industrial medicine. The rapid growth of communities throughout the country through the establishment of new defense industries presents serious health problems, all of which mean that the demand for medical services to the general public will increase as the national defense program expands, in addition to the 5% withdrawal of physicians from private life to the armed forces under the present program of the armed forces. It has been estimated that the increased demand will be approximately 10%.

From the above it is apparent there is an overall and increasing national shortage of medical doctors for service both to the armed forces and to the civilian population. Further, the supply is not distributed in accordance with the population so that consequently there are present shortages in some local board areas while on the other hand there are present surpluses in other local board areas. However, any such surpluses may be substantially reduced and even wiped out entirely by reason of the requirements of the armed forces and the increased civilian requirements as above indicated. The War Department has stated that it is now in need of medical officers and desires to commission duly qualified physicians and surgeons in the Medical Corps Reserve for immediate active duty of one year. Where a medical doctor, independent of Selective Service, accepts such a commission, he is in Class 1-C thus reducing the demand of the Army by one.

The local board has the problem of deciding whether or not an individual doctor is so necessary to a community that he should be deferred from training and service under the provisions of Paragraphs 350-353 of the Regulations. This problem should be approached with a clear appreciation of the overall national shortage. If the local board determines that he should not be deferred, it should call his attention to the provisions of the above-

mentioned memorandum (1-42) and encourage him to apply to the Corps Area Commander for commission in the Medical Corps Reserve. If he has been finally classified in 1-A and does not take advantage of this opportunity for commission he will be inducted when his order number is reached.

Currently there are approximately 5,000 medical graduates entering the profession each year. This represents the only source of supply for future requirements necessary to supplement the present force of the medical profession and to replace those leaving the profession. When it is realized that approximately 27,000 of the nation's physicians are 65 years of age or older, and that 3,800 are lost to the profession each year, this supply is not large.

Experience shows that not more than 60 to 65 per cent of medical graduates are physically and otherwise qualified for military service. Consequently, there is an acute demand for physically qualified medical graduates by the Army to serve as physicians. The civilian needs require approximately 3,800 graduated medical students each year to replace the physicians who are lost to the profession through normal attrition. The demand for these replacements is identical with the demand for doctors, since they constitute the only source of supply.

There are not replacements for medical students who are withdrawn from school. Consequently, if the supply of medical students who are to be graduated into the medical profession is reduced through their induction to serve in a non-professional capacity, an increasing reduction of physicians available for military service as well as an aggravation of the increasing overall national shortage will result.

It is of paramount importance that the supply be not only maintained but encouraged to grow, and that no student or intern who gives reasonable promise of becoming an acceptable medical doctor be called to military service before attaining that status. Local boards should remember that a deferment is not an exemption and that the obligation and liability for military service remains upon its expiration.

The internship is a period of hospital experience which follows the formal medical college course. It is considered an essential part of a medical education. The supply, demand and shortage of interns is identical with that set forth in II, above, with regard to Medical Students.

As interns are in the process of taking additional

training, the same policy and procedure prescribed with respect to medical students should be followed. However, we are informed that under the present War Department policy, interns who meet Army physical standards can be commissioned in the Medical Reserve Corps, and if so commissioned, will not

be called to active duty during the first year of internship. Consequently, even though a local board places an intern in Class 1-A by reason of determining that he can be spared from the community, such intern may, by becoming a member of the Medical Reserve Corps, complete his first year's internship.

PSYCHIATRIC CONSIDERATIONS IN THE SELECTION OF MILITARY PERSONNEL

LOUIS H. COHEN, M.D., *Norwich State Hospital*

The Author. B.A. *Yale University* 1926, M.A. 1927, PH.D. 1929, M.D. 1931. *Clinical Director Norwich State Hospital, Norwich*

MUCH HAS already been written about the contribution which psychiatry can make to the National Defense Program.¹ Various committees have been set up by the American Psychiatric Association and some of its regional societies.² Since the obvious first place in which the psychiatrist is useful is at the time of recruitment, a mechanism has been set up by which local draft boards have recourse to a Medical Advisory Committee and can call upon psychiatric consultants when psychiatric examination is felt necessary. From time to time draft boards in the eastern section of the state have sent draftees to the Norwich State Hospital for psychiatric examination. With the increasing volume of such referrals, it has become possible for us to study fairly intensively the psychiatric factors which concern given draftees, under the general question of whether or not they would make suitable soldiers. As part of our concern in this general problem we have also studied the literature which sprang up during the last war, and afterwards, as a guide in our considerations. It is my purpose in this paper to indicate briefly what the fruits of the psychiatric labors of World War #1 have been with reference to the selection of military personnel.

What we fear most as psychiatrists is that a man will crack under the specific conditions of war-time strain. The consequences of such a crack-up are the production of the problems of psychosis, so-called "shell-shock," or other psychopathic manifestations, such that military efficiency will be impaired during the crises of combat. The subsequent problems of the social and financial burdens imposed by invalid veterans need only be mentioned. At the risk of making this preamble too lengthy, I would like to point out also that all of us who have had occasion

to examine draftees are subject to the attitude of ambivalence implicit in all vocational selection. This ambivalence is expressed essentially in the question: "Will this man be a good soldier?" as against "Will this man crack up?" It has often been difficult, at least for me, to answer these questions in specific instances, and primarily for this reason: War is a terrible and grossly abnormal situation for all people, especially those of us who like to consider ourselves civilized. As such, our psychiatric considerations of the potential soldier must answer the question of whether his personality contains those elements of submissiveness to authority coupled with aggressiveness toward a potential enemy such that he can face the prospect of dying and of killing "without neurotic flight from either."³ Our problem of selection then becomes one of measuring clinically his tolerance for both these eventualities. If our opinion is that psychosis or shell-shock or any other kind of psychopathic manifestation might be precipitated by such circumstances the man must be rejected. On the other hand, we must consider him capable of being a "normal" soldier if no crack-up is predictable under conditions of such strain.

Certain specific facts concerning military psychiatry can be stated. From the experience of World War #1 we know that the psychoses in the army groups are of about equal incidence in peace and war. However, in war the incidence of the so-called "neuroses" is greatly increased, at least as far as their overt manifestations are concerned. It is a distressing fact that in the last war the military authorities did not always follow psychiatric recommendations. This is shown in the official American History of the Great War where it is stated that "8640 cases of nervous and mental diseases discovered in the United States were retained in the service, while in the opinion of neuropsychiatric officers they should have been separated from it."⁴ That the psychiatric problem was a cause of concern to General Pershing

Presented to the Connecticut Society of Psychiatry and Neurology at the quarterly meeting held at the Norwich State Hospital, March 20, 1941

is seen in his cable of July 15, 1918, shortly after the first contingents of the American Expeditionary Force arrived in France. "Prevalence of mental diseases in replacement troops recently received," he wired, "suggests urgent importance of intensive efforts in eliminating mentally unfit from organization's new draft prior to departure from the United States . . ."

Some statistics may not be amiss at this point. In an article written in 1914 by Bonhöffer⁵ during the first months of the war, it was reported that of one-hundred officers and men declared incapacitated for a mental disorder fifty three were of "psychopathic constitution."* The British Official History of the Great War⁶ gives the incidence of "functional nervous diseases" as 34 per thousand (of 1,043,653 casualties). On the basis of figures (excluding pensions), "by 1918 recognized authorities had expressed the view that the prevalence of neurotics was certainly not less than 10 per thousand among combatant troops, or 3 per thousand among home troops."³ In the German Army 5% of base hospital beds were kept for psychoneurotic casualties.⁷ In the French Army 1-5 beds per thousand troops were maintained in special psychiatric base hospitals, a practice subsequently followed by the American Army.³ On the basis of these figures the importance of elimination of such potential casualties by suitable pre-combat examination of troops cannot be denied.

CRITERIA OF SELECTION

The great problem is to set up suitable criteria to evaluate the factors which would serve as definite and generally acceptable psychiatric bases for acceptance or rejection of the draftee. That they may not be very satisfactory is shown in the study of 209 cases of so-called war neuroses by Gordon⁸ in the last war. His patients were investigated from the standpoint of the following five aspects:

- (1) Family history of mental disease.
- (2) Signs of gross nervous disturbances in childhood (epileptiform convulsions, enuresis, etc.).
- (3) Signs of physical disturbances in childhood (nightmares and terrors.).

- (4) Signs of failure to adapt himself to school life (avoidance of games, failure to make friends with other boys, etc.).
- (5) Signs of failure to adapt himself to civil employments.

With these criteria Gordon found that of 98 hysterics 20 showed definite symptoms of past abnormality; of 80 patients with anxiety, 31; of 6 patients with "exhaustion," 1; i.e., altogether 28.3% of all patients showed previous abnormality. Gordon's general conclusion was that more stress should be laid on the situation present when the breakdown occurred rather than upon these past factors.³ Apart from this conclusion, we could hold the opinion that his criteria might have served very well in "spotting" almost one third of potential psychiatric casualties.

Although no data as to the efficacy of the manner of selection are available, it is of interest to indicate that the characteristics used in judging recruits in the United States Navy which made him subject to discharge were the following:

- (1) Resentfulness to discipline or inability to be disciplined.
- (2) Unusual stupidity or awkwardness in drills or exercises.
- (3) Inability to transmit orders correctly.
- (4) Personal uncleanness.
- (5) Criminal tendencies.
- (6) Abnormal sex practices and tendencies, including masturbation.
- (7) Filthy language and defacement of property.
- (8) Distinct feminine types.
- (9) Bed wetters.
- (10) Subjects of continual ridicule or teasing.
- (11) Queer or peculiar behavior.
- (12) All recruits who show persistently the following characteristics: tearfulness, irritability, seclusiveness, sulkiness, depression, shyness, timidity, anti-social attitude, over-boisterousness, suspicion, dullness, sleeplessness, sleepwalking.
- (13) Chronic homesickness.

Not a very helpful list, obviously, especially when we have no data available on how effective in reducing the number of poor psychiatric risks these all-inclusive criteria were.

The most recent paper which has appeared is an

*It is interesting that Bonhöffer also stated then that these "persons, even if they are placed in hospitals and recover from their episodes are prone to become upset again if they return to train. It is better then to keep them away from the firing line." It is tragic that it was several years before the Allied Army awoke to this fact and heeded Bonhöffer's recommendations.

extensive, detailed statement by Baillie¹¹ which reports the first data of the present War from Canada. From his study of 200 consecutive admissions to the Christie St. Hospital, Toronto, he concludes that 68 (34%) of these men "should have been obviously unsuitable on enlistment, and 60 cases obvious in the primary training period." The significant factors seemed to be constitutional psychopathy (?), mental deficiency, poor physical and mental health of the family, poor economic status, illiteracy and poor school record, poor industrial record, a criminal record,* and previous history of "neurotic reaction, requiring attention, pre-enlistment."

One of the most significant papers which has come out of the present war is that by Curran and Mallinson^{9,10} in which a quite convincing case has been made out for the adoption of certain simple criteria which may serve as the basis for rejection. Their study has the virtue of some controlled data, and it is of interest to report this study in some detail, since it serves as the Norwich basis for final recommendations in given cases.

Curran and Mallinson studied 100 so-called psychiatric casualties in the Navy, and compared them with 50 surgical cases as controls. They summarized the material from their case-records under four headings:

1. *Family History*: This was considered to be positive when (1) a near blood-relation (parent, aunt, sibling) had been in a mental hospital or had attempted suicide; (2) more than one such relative had shown evidence of psychiatric disorder though not resulting in mental hospital treatment (shell-shock, obvious psychopathy as shown by chronic alcoholism or a very bad work record).

2. *Past History*: This was considered to be positive when there was clear objective evidence such as unsatisfactory work record; previous mental breakdown; repeated conflict with authority; a poor service record.

3. *Personality*: Characteristics which gave grounds for concern without causing gross inefficiency such as hysterical, paranoid or schizoid psychopathy, long-standing anxiety of pathological intensity, mental backwardness (standard V or lower at School), immature emotional development, and antisocial traits.

*The Selective Service System has issued orders to local draft boards that all registrants who have been convicted of a felony should be placed in Class IV-F to "avoid embarrassment" (See Survey, 72:66 (Feb.) 1940.)

4. *Physical Factors*: Such conditions as high blood pressure, arteriosclerosis, neurosyphilis, defective vision and influenza (?); these were only assessed as positive when they appeared to be not merely co-incidental."

They claim, "positive marks were awarded conservatively in the series of psychiatric cases, but we erred on the side of generosity when awarding them to the surgical controls. During the war of 1914-18, tectotalism, irritability of temper and tuberculosis were regarded as significant factors in etiology, but we have excluded them as too indefinite."

PREDICTABILITY IN RELATION TO DIAGNOSIS AND POSITIVE PSYCHIATRIC AND PHYSICAL FACTORS

DISORDER	PREDICTABLE CASES					UNPREDICTABLE CASES				
	NO. OF PATIENTS	FAMILY HIST.	PAST HIST.	PERSONALITY	PHYSICAL EXAM.	NO. OF PATIENTS	FAMILY HIST.	PAST HIST.	PERSONALITY	PHYSICAL EXAM.
Endogenous depression	9	6	6	4	2	22	10	5	5	2
Reactive depression	6	3	1	3	1	5	2	1	1	1
Mixed state	0	0	0	0	0	1	0	0	0	0
Maniac state	0	0	0	0	0	1	0	0	0	0
Psychopathic personality	6	3	5	6	0	2	1	0	1	0
Anxiety state	7	4	5	5	2	13	6	0	2	0
Anxiety & Hysterical state....	1	1	1	1	0	6	3	0	2	0
Hysterical state	5	1	5	4	1	8	4	2	4	3
Obsessional state	0	0	0	0	0	1	0	0	1	0
Enuresis	1	1	1	0	0	0	0	0	0	0
Hypochondriasis	0	0	0	0	0	1	0	0	1	0
Organic states	4	0	0	0	4	1	0	0	0	1
Total	39	19	24	23	10	61	26	8	17	7
		76					58			

Total positive factors in the 100 psychiatric cases = 134 (family hist. 45; past hist. 32; personality 40; physical exam. 17).

Total positive factors in the 50 surgical control cases = 32 (family hist. 6; past hist. 4; personality 6; physical exam. 6).

From Curran and Mallinson, *Lancet*, 2:738 (Dec. 14) 1940.

These data were obtained *after* the patients had been considered from the standpoint of predictability of breakdown. The authors state, "We attempted to assess how many breakdowns might have been predicted as the result of more thorough physical or psychiatric examination, either on recruiting or recall, or from their Service record. Considering each case as a whole we regarded 39 in the series of 100 predictable. The (foregoing) factors were worked out later."

From these data, their conclusions are: "In the

series of psychiatric cases it will be seen that the 39 predictable cases had 76 positive factors between them, whereas the 61 unpredictable had only 58. The proportion of positive past histories was high among the unpredictable cases. This suggests that in attempting to judge each case as a whole we undervalued the prognostic importance of a positive family history. Among the controls only 2 cases appear to have been a bad risk from the start—an alcoholic reservist with domestic troubles and a recruit with a past history of fits. Of the remainder, 3 had undergone much alarming experience and were considered to be of nervous disposition, and might have been doubtful risks if exposed to severe stress. None of them was highly abnormal."

PROCEDURE AT THE NORWICH STATE HOSPITAL

The examination of the referred draftee is given in three sections: (1) neurological, (2) psychiatric, and (3) psychological.

(1) *Neurological examination.* This examination consists of the usual routine procedure with the addition of precise visual field and roentgenologic investigations if the clinical findings warrant them. Particular note is made of tremors, including blepharospasm, undue sweating, peripheral vascular abnormalities, tics, and disturbances of finer coordination.

(2) *Psychiatric examination.* Here also a set routine is followed. Thorough questioning into the family history for evidence of psychotic, epileptic and psychopathic disorder is carried out. In the patient's past history, trauma, alcoholism, and criminality are inquired into and also questions concerning enuresis and night terrors are asked. The school and occupational records are evaluated. The draftee is encouraged to talk of his sexual life and practices particularly with reference to his heterosexual attitudes. The mental status is appraised with respect to formal psychotic disturbances, such as hallucinations, delusions, mood and activity disorders. Of central concern is the appraisal of his ability to focus attention and to comprehend fairly complex ideas.

(3) *Psychological examinations.* These are carried out by the consultant psychologist and include a battery of tests:

(a) *Stanford-Binet test.* This measures the mental age and the I. Q. A similar test which takes less time to administer and is quite reliable is the *Wechsler-Bellevue test*.

(b) *Porteus Maze test.* This is a "performance"

test and has value in measuring the ability for planning, control, and foresight.

(c) *Healy Picture-Completion test.* This test is an indicator of the traits necessary for "social adjustment."

If time permits other tests are also employed, but from the above-mentioned three an adequate picture of these significant psychological functions can usually be obtained.

When all the data from the neurological, psychiatric and psychological examinations have been gathered, the draftee is discussed by the examiners. A decision is then made concerning the nature of his qualifications for military service. It is felt that with such full information a fair final judgment is made.

It is of interest to note that up to the present time 9 draftees have been rejected by us. These include men who were disqualified for the following reasons: schizophrenia (2 cases); severely tainted family background (1 case); alcoholism (1 case); feeble-mindedness (2 cases); post-traumatic personality disorder (1 case); psychopathic personality (psychosexual infantilism, homosexuality) (2 cases).

CONCLUSIONS

In conclusion, attention should be called to an extremely valuable volume edited by Doctor Emanuel Miller³ in which the following paragraph (p. 177) appears. It gives in summary a rational program for the psychiatric evaluation of men. "Firstly, in each recruiting area there should be available psychiatrists with experience of psychoneuroses to whom the boards may refer men on enlistment. Secondly, it is of extreme importance that referral for special psychiatric investigation should be made on the basis of the reaction to certain phases of early training; for example, as soon as military life has made obvious any difficulties over subordination or aggressiveness, on recognition by instructors of certain listed behavior characteristics, or on display of abnormal reactions to the first gas or bayonet drill . . . So far as possible these routine referrals should be completed before the end of training, so that men may feel satisfied that they have passed all tests of military fitness. Naturally, the practical test of line service should once again bring into operation the mechanism outlined above, allowance being made for a period of adaptation to these new conditions."¹² These recommendations are reasonable and practical. It is a pity that despite all the tumult and shouting of the contributions of psychiatry to our

Defense Program very little in the setting-up of such a program has yet been done.

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Important Role of Physical Therapy in the National Defense Program

Nearly twelve precious months have passed and physical medicine finds itself today in a cul-de-sac relegated thereto by well intentioned officials who unfortunately either have been bound down by the web of red tape or concomitant responsibilities that has made routinism the easiest way out to an unfamiliar problem. Organized medicine failed to recognize the place and responsibility of physical therapy in the scheme of reconstructive service in national defense and official Washington in its apparent unawareness of the historic role played by this specialty in the last World War, has in a sort of somnolent fashion made an executive gesture which

if carried out promises to reduce this positive therapeutic practice to a futile state. This situation with reference to the relation of physical medicine to national defense is therefore so confusing and its present status in the scheme of organizational recognition so negligible that little is to be wondered at the growing apathy, indifference and discouragement now evident within its rank.

Arch. of Phys. Ther., April 1941.

New Exchange Journal

This month we add to our exchange mailing list *The South African Journal of Medical Sciences*, published at Johannesburg by the Medical Graduate Association of the University of The Witwatersrand. This exchange will make the Connecticut State Medical Journal available for consultation throughout Union and Rhodesia.

Demand for Medical Personnel In War Industries is Growing

The demand for more and better trained medical personnel in war industries, under both governmental and private control, is steadily becoming more insistent. The scarcity of competent industrial nurses, engineers and physicians accords with an early impression of the Committee on Medical Preparedness of the American Medical Association; one of the first resolutions of the committee called for prompt organization and adequate support of training facilities for physicians interested in this field.

In a large group of industrial workers the proportion of the cases of tuberculosis found in a minimal stage has almost trebled since 1929. Moderately advanced cases have decreased slightly and far advanced cases are about one third the former proportion. This change is explained largely by the fact that in recent years fluoroscopic examinations of the chest (and poentgenograms when indicated) have been made prior to employment and as part of the annual routine examinations of all employees of the Metropolitan Life Insurance Company.

From *Bulletin of Met. Life Ins. Co.*

Three million dollars a month is being spent on tuberculous soldiers today. Flatly, it costs around \$10,000 to induct a man suffering from tuberculosis and \$50.00 a month for the rest of his life, plus compensation benefits for his dependents after his death.

D. B. Craigin, M.D., Med. Dir., Aetna Life Ins. Co.

THE LEGISLATURE

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LEGISLATIVE COMMITTEE RECOMMENDS EMPLOYEES IN STATE INSTITUTIONS BE EXEMPT FROM THE MERIT SYSTEM

The Legislative Committee to Study the Operation of the State Merit System, headed by Representative Mitchell of West Hartford has recommended in its report to the General Assembly "that all employees of State institutions which are governed by a commission or board of trustees responsible by statute for the administration of such institutions be exempted from the Merit System."

In its report the Committee stated that evidence was "overwhelming that institutional services are hurt by the operation of the Merit System. Delays in filling positions are hampering to a greater extent in institutions than in departments. Questions of personality are more important in institutional work than in departments. The intangible factors in institutional work cannot be appraised definitely in all cases. Institution heads are often loath to discharge employees even though they are certain that the discharge would be to the advantage of the institution because of the difficulty of proving charges of incompatibility. . . . The greatest institutional difficulty and delay is with respect to employees who are in responsible technical or professional positions. The two-year rule, indeed any residential rule, is a handicap when it comes to obtaining doctors, nurses and skilled institutional help. Such professional and skilled employees of the quality necessary will seldom come from far away to take examinations, and it is extremely difficult to obtain them on a provisional basis."

The Committee went further to say: "It must always be remembered also that in institutional management of a high degree of personal loyalty and confidence must be maintained. The Merit System is not conducive to such loyalty and confidence."

The General Assembly

By the time this is published the 1941 General Assembly will be a matter of history. What may occur during the final days of the session no one may safely forecast. Up to the present the session has been marked by things that it has not done rather than things accomplished.

The status of measures of which the State Medical Society is interested has changed very little during the past four weeks.

THE OSTEOPATHIC BILL

The hearing on S. B. 519—An Act Concerning Osteopathy—was well attended by members of the Society and the brief presented by the Society in opposition to the bill was published in the May Journal. The Committee on Public Health and Safety has filed an unfavorable report on the bill.

THE MEDICAL PRACTICE ACTS

The Society's proposals to amend the Medical Practice laws have been heard before the Committee on Public Health and Safety and were not opposed in any considerable measure. The question of citizenship has received some discussion and as yet the Committee has not reported on the bill.

THE PRENATAL WASSERMANN BILL

The Society's Prenatal Wasserman Bill was favorably reported by the Committee on Public Health and Safety and has lately been recommitted to the Committee for the purpose of changing its phraseology.

INCREASED QUALIFICATIONS OF THE HEALTH COMMISSIONER

A bill that would require future appointees to the office of State Health Commissioner to have had

graduate instruction or a degree in Public Health has been passed by the House.

HEALTH REGULATIONS BY THE DEPARTMENT OF LABOR

A bill that would give to the State Department of Labor and Factory Inspection the responsibility for making regulations concerning occupational diseases health and industry was opposed by the Society. The bill has not yet been reported out by the Committee on Labor.

AN ACT CONCERNING CREMATION

The bill introduced by the Society that would require permits for cremation to be signed by the Medical Examiner instead of the Health Officer has been favorably reported by the Committee on Public Health and Safety and tabled.

STUDY OF THE CHRONICALLY SICK

The measure that would create a commission for the study of the care of the chronically sick in the State which had been previously reported favorably by the Committee on Humane Institutions was recommitted and has been reported unfavorably. The reason given was the desire to cut down the number of special commissions for studying specific problems.

WAIVER FOR TRAINED ATTENDENTS' CERTIFICATES

The substitute for H. B. 1069—An Act Concerning the Extension of Waiver for "Trained Attendant" Certificates has been favorably reported. The bill would extend the period of certification of trained attendents without examination to January 1, 1942.

Federal Legislation

WAGNER HOSPITAL BILL

During the past month the Senate Committee on Education and Labor designated a subcommittee to give consideration to S. 1230, the bill introduced by Senator Brown of Michigan, for himself and Senator Wagner of New York and Senator George of Georgia, proposing to provide for a hospital construction program. The subcommittee is composed of the following members: Senator Murray, Montana, Senator Ellender, Louisiana, Senator Bunker, Nevada, Senator LaFollette, Wisconsin, and Senator Taft of Ohio. No hearings on the bill have been scheduled as yet. It will bear repetition that this bill is identical with the old Wagner-George hospital construction bill of the Seventy-sixth Congress, as

it passed the Senate. The bill therefore contains the broad definition of the term "hospital" to include health, diagnostic and treatment centers, it provides for osteopathic representation on the National Advisory Hospital Council, and it gives insufficient authority to that Council with respect to projects to be constructed after the first year of the operation of the building program.

VENEREAL DISEASE IN THE ARMY

The bill introduced by Representative May, of Kentucky, H. R. 2475, to prohibit prostitution near military or naval establishments has passed the House of Representatives. As explained in the report of the House Committee on Military Affairs:

"The principal objective of the bill, if not the only objective, is to prevent the spread of venereal diseases among the hundreds and thousands of young men being brought into the Military Establishment under legislative enactment heretofore passed and approved by the President and from evidence presented to the committee it appears that simultaneously with the augmentation of the organized forces of the United States, that thousands of women of ill repute have become camp followers and are assembling in adjacent communities to practically every Army post and cantonment throughout the country for the purpose of engaging in immoral and illicit conduct, and particularly with a view to such association with the troops in the Army posts and cantonments in many sections of the country. It has been clearly established that thousands of such women are traveling by train, automobile, and in trailers and setting up camp in the immediate communities of the Army posts and cantonments, notwithstanding that the Army and Navy have sought in every way to protect these enrollees and enlisted men, as well as the regular armed forces from such temptations and associations.

DEFERMENT AND EXEMPTION OF PHYSICIANS AND MEDICAL STUDENTS

There has been a revival of activity in connection with the Murray bill, S. 783, relating, among other things, to the deferment of the selection of medical students, interns and residents. Following the conclusion of the hearing on the bill, it was reliably reported that the bill had been tabled by the Committee which, of course, carried the inference that no further consideration would be given it. Subsequently, however, to be exact, on April 29, the Senate Committee on Education and Labor, or a

subcommittee thereof, again brought up the bill for discussion with the view of taking action on it. No definite conclusion was reached on that day and further consideration of the bill was postponed until May 2. In the meantime Senator Murray has appealed to the several State Associations, and to the American Medical Association, for support of the bill.

H. R. 4418, introduced by Representative Faddis, Pennsylvania, April 18.—A bill to amend the Selective Training and Service Act of 1940. Pending in the House Committee on Military Affairs.

This bill is identical with the Murray bill relating to the deferment of medical students as introduced in the Seventy-sixth Congress and as reintroduced in the present Congress as S. 197.

CRIPPLED CHILDREN

H. R. 4485, introduced by Representative Collins, Mississippi, April 23.—A bill providing that the federal contribution to States for aid to crippled children under the Social Security Act shall be determined according to financial need for assistance. Pending in the House Committee on Ways and Means.

Under existing law the Secretary of Labor allots to each State for each fiscal year \$20,000, apparently an outright gratuity, for services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and after care, for children who are crippled or who are suffering from conditions which lead to crippling. In addition, \$1,830,000 is allotted to the States according to the need of each State as determined by the Secretary of Labor after taking into consideration the number of crippled children in such State in need of the services referred to in the preceding sentence. An additional sum of \$1,000,000 is allotted each year to the States by the Secretary of Labor "according to the financial need of each State for assistance in carrying out its State plan," as determined by the Secretary of Labor after taking into consideration the number of crippled children in the State in need

of services. The pending bill would simply provide that from the sums appropriated for each fiscal year the Secretary of Labor shall allot "to the States according to the financial need of each State for assistance in carrying out its State plan, as determined by him after taking into consideration the number of crippled children in such State in need of the services." The amendment would therefore seem to do away with the \$20,000 sum authorized to be paid to each State each year, regardless of the number of crippled children in the State and regardless of the financial needs of the State, and would condition further federal allotments on a showing of financial need.

HOSPITAL CONSTRUCTION

S. 1375, introduced by Senator McCarran, Nevada, April 25.—A bill to provide for certain community facilities made necessary by the exigencies of national defense. Pending in the Senate Committee on Education and Labor.

As used in the bill, the term "community facility" means (a) buildings, grounds, and incidental equipment (including transportation) for grammar schools, high schools, hospitals, and clinics; (b) sewerage and water systems; and (c) facilities, including buildings, grounds, and incidental equipment, to provide for the welfare of the members of the land and naval forces of the United States.

Insurance Plan Discontinued

It should be a matter of no small interest to those interested in voluntary sickness insurance that an experiment in voluntary sickness insurance carried on for several years by the Douglas County Medical Society in Superior, Wisconsin, was recently discontinued. Discontinuance of a somewhat similar trial plan in Milwaukee was also announced. Reasons given were: First, exceedingly small demand; second, high cost of acquiring subscribers; third, plan did not reach low income group; fourth, high operating costs; and fifth, premiums too small to permit payment of minimum standard fees to the physicians.

W. Va. Med. Jour., April, 1941.

DRIP! DRIP! DRIP! — Doctors and surgeons everywhere are enthusiastic about the new "DryBrow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "DryBrow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.

COMMITTEE ON INDUSTRIAL HEALTH

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Conservation of Man Power

A PROGRAM FOR THE EXTENSION AND IMPROVEMENT
OF INDUSTRIAL MEDICAL SERVICE IN CONNECTICUT*

*Prepared jointly by the Committees on Industrial
Health of The Manufacturers Association of
Connecticut and The Connecticut State
Medical Society*

The national preparedness program creates demands which tax production severely and put a premium on the physical well-being of employees. Health problems of normal periods are accentuated and new ones will be created, as industry speeds operations, employs untrained and physically defective employees, and institutes new processes of unknown or detrimental health significance.

Such problems will arise at the very time when the physical fitness of each employee will have a marked influence upon the extent to which industry will meet the abnormal demands for its services.

Aware of the health problems which confront industry during normal times and cognizant of the intensification of these hazards during periods of increased industrial activity, the Joint Committee offers the following suggestions for the extension and improvement of industrial medical service.

OBJECTIVES OF INDUSTRIAL MEDICAL SERVICE

The purpose of industrial medical service may be stated to be the preservation and promotion of the health of employees. This implies first of all, the provision of a safe and congenial environment for every employee and, secondly, his proper placement and advancement within the organization through

*The material, herewith presented in condensed form, was embodied in a brochure, which was distributed to members of The Manufacturers Association of Connecticut and of The Connecticut Chamber of Commerce.

CONSERVATION OF MAN POWER

through
EXTENSION AND IMPROVEMENT
OF
INDUSTRIAL MEDICAL SERVICE



prepared by
THE CONNECTICUT STATE MEDICAL SOCIETY and

THE MANUFACTURERS ASSOCIATION OF CONNECTICUT, Inc.

April 15, 1941

Hartford, Connecticut



BROCHURE DISTRIBUTED TO INDUSTRIALISTS

competent evaluation of the employee as a physical and mental being.

Improved health and more effective utilization of man power should make for a better product. Less sickness and fewer accidents should result in less compensation cost, fewer unjust claims for injuries, less absenteeism, less labor turnover and, hence, a better production schedule. A better product and a healthier, and consequently happier, personnel should increase company goodwill.^{1,2}

The employee as well as the employer has an obligation in respect to the maintenance of health. Every employee is expected to utilize the safety measures provided by the plant. It is obvious that labor and industry each have definite responsibilities to the other concerning the protection of health. Efficient industrial medical service of the type outlined below should be beneficial to both in their efforts to bring about better health conditions and in improving general industrial relationships.

FUNCTIONS OF THE SERVICE

The type of industrial medical service under consideration deals with the following activities:

1. Control of Plant Environment.
 2. Physical Examinations and Supervision of Employees.
 - a. Pre-employment Examinations.
 - b. Periodic Examinations.
 - c. Transfer Examinations.
 - d. Examinations Following Absence.
 - e. Records and Procedure.
 3. Therapy.
 4. Special Investigations.
 - a. Studies of Accomplishments.
 - b. Other Special Studies.
 5. Education.
1. *Control of Plant Environment*

The physician is actually the health director of the plant and responsible for all phases of preventive medicine. He should have a thorough knowledge of all processes and materials being used and of the actual and potential health hazards involved. It is the physician's duty to see that the employees are adequately protected against any conditions which might cause illness or injury. The provision of proper safety measures and the identification, measurement, and control of dusts, fumes, gases, etc., usually are the immediate responsibility of the safety engineer or others, but the plant physician should be able to assist in the evaluation of the extent of these hazards and the effectiveness of control measures, for he sees the physical effect upon the employees of the lack of these measures.

Plant housekeeping, toilet facilities, drinking facilities, lighting, heating, ventilation and air conditioning also play important roles in the health and safety program of any plant. The extent to which the plant physician concerns himself with these considerations—all preventive phases of his work—will determine to no small degree the effectiveness of the services he renders.

One of the most satisfactory ways for the physician to assist in controlling plant environment is to inspect periodically the plant and the personnel en masse, submitting a written report of his findings on a special "Plant Inspection" form. He should be accompanied in the tour about the plant by an official of the company so that remedial measures may be pointed out.

2. *Physical Examinations and Supervision of Employees*

Physical examinations of employees are an important part of medical service in industry. They are useful in determining the physical fitness of applicants for employment; in permitting the proper placement in the organization of the defective or older worker (particularly important in times of preparedness); and in measuring the progress of efforts to control occupational hazards. Likewise, physical examinations are beneficial to all in industry because physical defects are discovered oftentimes when correction is still possible.

Physical examinations of employees may be classified according to type, as follows:

a. Pre-employment Examinations.

The pre-employment or placement examination should be made, as the name implies, before the applicant is employed, so that his physical fitness for any duty can be determined.

The extent of the pre-employment examination cannot be defined here for all industrial conditions, but some general phases may be mentioned. Whenever practical, a careful clinical and occupational history should be taken and the examination should include vision, hearing, blood pressure, the heart and lungs, spine, extremities, abdomen, inguinal rings, etc. Routine urinalyses should be made and under certain conditions it is desirable to include blood Wassermanns, chest x-rays, and other diagnostic procedures.

b. Periodic Examinations.

Employees exposed to hazardous conditions or in charge of operations which may be hazardous to other employees should be examined as frequently as the circumstances indicate. These examinations may be limited to a few essential observations and laboratory tests depending upon the early manifestations of the occupational disease.

Employees showing evidence of occupational disease should be removed from exposure and appropriately treated. Necessary steps should be taken to control the hazard. The disease should be reported

on forms provided by the Bureau of Occupational Diseases of the Connecticut State Department of Health.

Periodic physical re-examination of all employees whether or not exposed to hazardous conditions is desirable at least every one or two years. When this is not practicable, partial physical re-examination, depending on findings at time of the last examination, and selected laboratory tests may be employed. Other minimal types of periodic rechecking of employees are possible such as the employment of a personal history form without physical examination, aiming to ascertain whether symptoms or warning signals are present, with the idea of referring selected cases to their family physician.

Periodic re-examination should include office as well as factory employees. The inclusion of executive personnel in particular often has the beneficial effect of selling the examinations to the other employees.

Periodic examinations of members of employee mutual benefit associations are desirable in order to lower morbidity and mortality rates. If examinations of this type are made the records must be kept strictly confidential, and neither membership in the association nor benefits derived should be affected by the results of the examination. Depending on the method of financing accident, sickness and death benefits, examinations before admission to the association may also be indicated.

c. Transfer Examinations.

Employees to be transferred permanently or for an indefinite period from one job to another varying in nature and physical requirements from the original occupation, should be examined prior to the transfer to determine any harmful effect of the old job as well as their physical fitness for the new one. This refers not only to transfer to heavier work but in certain instances, as in the case of older or disabled employees, to other work more suitable to their physical capacity.

d. Examinations Following Absence.

Employees returning to work following absence because of illness or injuries, or after prolonged absence for any reason should be subject to examination in accordance with a plan acceptable to the company physician.

e. Records and Procedure.

Detailed information is readily available concerning the scope of the comprehensive physical examination and forms to be used for recording both the

pre-employment and periodic re-examination.^{3,4}

Where there are important physical findings the employee should be advised to request his family doctor to get in touch with the examining physician. When requested, a detailed report should be sent to the family doctor.

Complete records of all findings, instructions, estimates of disabilities, etc., should be kept strictly confidential and be available only to the physician in charge or those under his supervision. Codes or other forms of physical classification may be submitted to the proper officials so that they may know only the employee's physical fitness for work.

The decision of the physician should be respected in all matters relating to the physical fitness of, and medical care needed by, the examinee. All reportable diseases, occupational or non-occupational, as well as accidents should be brought to the attention of the proper city or state officials.

3. *Therapy*

The therapeutic functions of the industrial physician should be limited to the care of occupational injuries and diseases, in accordance with the Compensation Act of Connecticut;⁵ to the physical rehabilitation of injured workers; and to first aid and other minor illnesses of non-occupational nature for which the employee would not ordinarily consult his family doctor. The plant physician should not assume any functions in connection with his duties in the plant which belong to the personal or family physician.

4. *Special Investigations*

a. Studies of Accomplishments.

An important phase of the industrial physician's duties involves the evaluation of efforts to safeguard the health of employees. Complete records should be kept of all services rendered; of sickness and accident experiences; particularly those causing absence from work;⁶ of special control measures which have been installed, and of costs of medical service and of compensation. Periodic analyses of these data according to departments or occupation, particularly the determination of accident frequency and severity rates, represent one of the best possible means of measuring accomplishments and substantiating claims for the continuation and expansion of the medical service.

b. Other Special Studies.

The factors and circumstances which do or may impair the health of industrial employees present

many opportunities for study to the progressive industrial physician. It is not advocated or expected that industrial physicians devote a major portion of their time to research or specific investigations. However, it is desirable that whenever new processes or materials are introduced into a plant, the industrial physician should be notified immediately by the management, in order that he may be on the alert for any new occupational hazards.

Under the stress of the national preparedness program a number of universities are extending their research activities to include industrial medicine. Industry and the industrial physician should be afforded the opportunity to participate in, or to benefit by, those studies.

5. *Education.*

Education is a fruitful phase of service for industrial physicians. Industrial employees may be willing to do their part in safeguarding their health at the plant, but they may not know what to do or how. Likewise employees do not always fully understand the nature of some of their personal health problems or how they may be brought under control.

The opportunities of the industrial physician are many for showing both employees and employers alike how they can make greater effort to safeguard their general health, increase their personal efficiency, reduce absenteeism, and utilize to the best possible advantage the control measures instituted by the plant.

The inauguration of American Red Cross first aid courses will serve as a medium of safety education and as a means of stimulating employee activity and interest in the healthfulness and safety of the working environment.

ORGANIZATION OF THE INDUSTRIAL MEDICAL SERVICE

The character of industrial medical service will vary with individual needs, but certain minimum standards have been advocated.³ It should be borne in mind that such standards are to be considered as basic ones only and that they may be below the actual needs of many types of industrial organizations. On the other hand small companies often begin with less and build up their medical services as fast as conditions warrant.

The medical department should be conveniently located and adequately equipped. The physician in charge should be given sufficient authority and freedom to facilitate the most desirable relationships within the plant and at the same time be permitted

to deal with the employees in the same ethical and considerate manner as would be expected in private practice.

Whether the physician should be engaged on a full-time or part-time basis should be governed by individual plant needs.

The question whether the doctor should be a surgeon or not is often raised. In some plants surgical services represent the greatest medical need while in others, not having important accident hazards but definite problems of disease control, a well trained internist would be more suitable than a surgeon.

Registered nurses perform a necessary and important function in any well-developed industrial health program. Requirements will vary with the plant and should receive individual consideration. Nursing services should always be under the supervision of the plant physician.

PLAN FOR ASSISTING INDUSTRIES IN DEVELOPING THEIR INDIVIDUAL MEDICAL SERVICE

Upon request, the Joint Committee on Industrial Health of the Manufacturers Association of Connecticut and the Connecticut State Medical Society will be glad to study the individual medical problems of any industrial establishment in the state, in coöperation with its medical personnel, or when such personnel is not available, with other company officials.*

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*In the brochure distributed to industrialists an inquiry form was enclosed which served the dual purpose of eliciting a statement concerning present industrial medical facilities, which will serve as the basis of a state-wide survey, and of providing the recipient the opportunity to request advice in developing his medical service.

ANNUAL REPORTS

REPORT OF THE EXECUTIVE SECRETARY HOUSE OF DELEGATES MAY 20, 1941

In presenting a report of an over all picture of the activities of the Society which is undoubtedly expected from the Secretary, there is, of course, danger of being repetitious and reporting things that will be covered in detail by other officers of the Society. This hazard is well realized and there is no intent to trespass upon the prerogative of other officers and committee leaders. However, a clearer picture of the Society's operation and progress may be had if its many activities are integrated in a single report.

Membership:

A detailed report of the changes in membership for the year 1940 has been published in the JOURNAL and is now reprinted in the agenda which is before you. It is to be noted therein that during the year 1940, the first year of the increased dues, the Society showed a net gain of 36 members. This was a most gratifying result to those who believed the field of usefulness of the Society should be broadened and that the physicians of the State would be willing to meet the necessary expense. We entered the year of 1941 with 1759 members and at the annual meetings of the county associations in April 84 new members were elected so that today the total membership of the Society is 1825, the largest that it has been in its 150 years of operation.

A year ago provision was made for exemption from dues for physicians who had been members of the Society for a long period of time. It was estimated that there were about 80 members of the Society who would be eligible for this exemption. At present 27 of them have been exempted under this provision of the By-Laws.

In December 1940 the House of Delegates at its special meeting passed a resolution that would exempt members in the military service from the payment of dues during the period of that service. The number of Connecticut physicians who have joined the colors is steadily increasing and at present there are about 41 who are temporarily out of the state serving with the armed forces. Of these 16 have asked for exemption from payment of dues.

Finances:

While it is the province of the Treasurer to report concerning the finances of your Society there are two or three points which I would like to bring to your attention. First, each of the separately budgeted agencies within the Society operated well within their budgets for the year 1940. Second, in setting up the budget for the year the income from dues had to be estimated, and it is pleasing to note that estimate was only about \$250.00 off. Third, the Society had an ample operating surplus for the year which was in no small part due to the fine financial showing made by the Journal.

The Council:

The Council has continued to give careful consideration to the management of the Society's affairs and I wish here to express my appreciation of their understanding willing-

ness to carry the Society forward into new areas of purpose and service. Except for the annual addition of the President-Elect to the Council it now appears that there will be but one change in the membership of that body. Doctor Whalen has asked not to be returned as the Councilor from Hartford County and he will be succeeded by Doctor Landry who is now the Society's President. We will miss Doctor Whalen on the Council for his ready willingness to participate in discussions and aid in decisions has at all times been valuable.

The County Associations:

The relationship of the State office to the offices of the secretaries of the county associations has been strengthened during the past year. Some of the minor misunderstandings arising from changes in the system of administration have been straightened out and I wish to express my appreciation of the efforts and work that the secretaries of the county associations have given to make this year so successful. Doctor Carl Wies, who for several years has been the secretary of the New London County Association, has been replaced by Doctor Thomas Soltz and a treasurer has been added in the New London County Association; Doctor Solam Segal occupies that office. The state headquarters will continue to give every coöperation to the county associations in helping to interest new members, in assisting in administration and in the arrangement of programs. There is never any intent to disturb the autonomy of the county associations, but there is a continuing willingness to be helpful to them.

Contact with the American Medical Association:

This Society has continued to develop a close personal and administrative relationship with the American Medical Association. Officials of the Association have at all times been generous with their assistance to us. I have visited headquarters once during the year and representatives of the Society in the fields of medical licensure, medical preparedness and industrial health have attended conferences at the Chicago headquarters. We have freely called upon the Bureau of Legal Medicine for advice and I am pleased now to express my appreciation for the service we have received from the officials in that Bureau.

Medical Preparedness:

Much might be said here concerning the Society's substantial entry into the program of medical preparedness, but it is appropriate that such should be left to the report of the chairman of the special Committee on that subject. However, I wish to take this opportunity to thank the chairman of the Committee and the eight county chairmen for the thoughtful and time consuming work they have done, especially in connection with the organization of the medical personnel in the Selective Service. It is clear to anyone who understands the physicians in this or any other state that choosing the personnel for this organization had to be approached with fine tact and discrimination. In the ability to understand that situation lay the great advantage of having the Boards set up by the medical profession itself rather

than through a political agency. Our system worked well here, indeed, it has been pointed out as a model by higher authorities. The relationship of the State Society to the Selective Service officials through the pleasant liaison provided by Major William B. Smith has at all times been agreeable and productive. Red tape has been entirely eliminated and the whole complex procedure has gone along in a friendly and informal fashion.

The donation of \$600.00 from a generous anonymous member of the Society to meet the unusual expenses of our preparedness program has been ample and I believe that the gratitude of the Society to this member should be again expressed.

Committee on Public Health:

The Committee on Public Health gives consideration to a broad field, it is by no means solely concerned with the matters usually considered to be of a public health nature and frequently extends its considerations to the field of economics. It is one of the most active of the Society's Committees and serves as the chief contact between the Society and the government. The Committee continues to enjoy a fine reciprocal relationship with the State Department of Health and the members of the Committee are deserving of commendation for the time and effort that they have expended in our interest.

Tumor Committee:

Throughout its history this Society has been concerned with matters of public concern and has taken leadership in the program for the care of the insane and the tuberculous and in medical licensure. At its Annual Meeting eight years ago the Society adopted a resolution authorizing the appointment of a Tumor Committee. The first objective of the Committee was to establish a Division of Cancer Research. The efforts of the Committee culminated in the passage of a law by the General Assembly of 1935 authorizing such an agency of government with the State Department of Health. During the years since then the Society's Tumor Committee and the Department of Health have worked in the closest coöperation in the establishment and operation of more than twenty diagnostic tumor clinics maintained on a voluntary basis throughout the State and the accumulation of a tumor register for the State. This year the Tumor Committee and other members of the Society directed their interest to increasing the appropriation made available to the Division of Cancer Research and through their efforts two annual appropriations of \$25,000.00 have been obtained from the State for this purpose.

The Committee has for some time had under consideration joining itself to the American Society for the Control of Cancer and during 1940 the State Society's Committee has incorporated as the Connecticut Branch of that Society.

In a community with an ageing population such as Connecticut has the problem of cancer is of increasing social and economic importance and this Society may look with justifiable pride upon the leadership that one of its committees has again taken in the field of public service.

Prepaid Medical Service:

The Society has for two years had a Committee under the chairmanship of Samuel C. Harvey, studying prepaid

medical service. The report of that Committee's deliberations is before you. In its brevity it by no means shows the amount of work or the breadth of the considerations that the Committee applied to the problem of prepayment for medical service. The Society, and in fact the people of the State, are indebted to this Committee for the effort it has put forward and the fine judgment it has exercised. During the present time of industrial activity and full employment it may appear that there is no need for a device to spread the cost of illness and there will be a temptation to lay aside the report of this Committee and its deliberations. Such a procedure would, I believe, be a mistake and the present period of prosperity should be welcomed as a time when this complicated problem may be carefully studied so that finally a well considered and workable plan may be evolved.

Public Relations:

In my two previous reports I have directed your attention to the necessity for the Society to develop an adequate and appropriate policy in public relations. Medicine now plays an increasingly important role in society and the people demand that they be kept informed. Much of this education and information has properly enough come from public health authorities while organizations of private practitioners of medicine have been backward or reluctant to further their own professional public relations. This attitude of mind is gradually disappearing and led by the American Medical Association the more alert state medical societies are now embarked upon programs of information for the public, and dignified efforts to bring the public to the realization that medical organizations are interested in maintaining and improving the quality of medical care.

Operations in the field of public relations are not easily estimated by physicians and the first efforts of this Society in this connection were not conspicuously fruitful. However, the Society's present Committee on Public Relations has approached the problem deliberately and with good judgment and it is to be anticipated that its progress will develop a sound and workable policy for the Society.

In the year that lies ahead it seems likely that we shall be called upon to face new responsibilities in connection with national defense and public service. I believe that we can meet those responsibilities without uncertainty and with the assurance that we are organized and prepared to take an important place in public and professional affairs.

REPORT OF THE COUNCIL TO THE HOUSE OF DELEGATES

Gentlemen:

In rendering my first account of the transactions of the Council, I am frankly embarrassed by the wealth of material which I could report to you. This has been a very busy year as those of you who have followed the Journal carefully have been able to see. It is my purpose, however, to speak of some items which call for more extended comment.

The county councilors have all reported their associations to be in flourishing condition. Full representation of the various counties has been in attendance at the Council meetings. Each councilor has worked diligently to increase membership in his county association.

The most important single item of business during the past

year has been the development of the Medical Defense Program. The national and state programs have not developed entirely within the framework of our medical organization, nevertheless the State Society, through its Council, has been constantly in touch with the situation and we have been fully informed of every step taken by the Medical Defense authorities. The Council approved the selections of physicians for the selective service program and the success of the program attests the wisdom of those selections. To Doctor George M. Smith and to his county chairmen, the Society owes a tremendous debt for what they have done and for what they are still doing.

The Council disapproved the use of special listing for physicians in telephone directories. It delayed action on the formation of a Women's Auxillary for the State Society.

The Council approved the coöperative efforts of the Committee on Industrial Medicine, under Doctor Kuh, and the Connecticut Manufacturers Association. The Council is fully aware of the rapidity with which this field of medicine is developing and wishes to commend the committee on the progress which they have made.

At the request of the United States Public Health Service, a joint study was made by this Society and the State Department of Health, on the evaluation of the quality of serological tests for syphilis performed in this state. The Council approved this outstanding piece of investigative work. It will be of great use to the physicians of the state and the report will appear in the Journal.

Representatives of the nursing profession attended one of the Council meetings and participated in a discussion of mutual problems concerning registration of trained attendants. Such conferences always tend to reduce friction and to encourage coöperation among those who are interested in the joint enterprise of providing medical care. Our Society has at the present time conference committees with the pharmacists, with the nurses, and with hospitals, and your Council has recommended that a joint conference committee with the State Dental Association be authorized. As an instance of coöperation with the Hospital Association the Council approved a joint letter which can be sent by individual hospitals to individual draft boards to procure deferment of call to military service of an interne whose services are deemed necessary to the hospital.

Your Council considered at length the bill on Tax Supported Medical Insurance, introduced by Senator Bingham, and you are familiar with the memorandum which it adopted on March 12th.

"1. The Society is interested and will further any reasonable measure that will benefit the health of the people of Connecticut and improve the distribution of medical care within the State.

2. The Society is of the opinion that since there is no experience with compulsory health insurance in America that the State of Connecticut should proceed with caution and that a thorough study of the subject as it applies to this State should be made before definite legislative action may be properly considered.

3. The Society expresses its willingness to coöperate to the fullest extent of its skill and resources with the State agency that is directed to study the need for an application

of compulsory health insurance in this State."*

Your Council believes that we are on solid ground when we adopt a policy of full coöperation in the study of plans which are aimed to bring good medical care to the people of our state. Organized medicine too often has been accused of obstinate refusal to study such plans. Many of our members I am sure have come to feel a sort of defeatism, reluctantly yielding to the irresistible forces of change which Society appears to be setting in motion. If and when, serious consideration is given to the development of plans for medical care in our state, our association is now in a position where it will inevitably be called on to sit in on the formulation of such plans, not as outcasts, but as experts. Our tactical position before the public is greatly improved.

The Council has considered very carefully the relationship of physicians to the State Hospitals which from time to time call upon physicians to render special care to their inmates. This matter, as you know, was brought to our attention particularly by the move to establish a volunteer staff at the Veterans Home at Rocky Hill. A policy was formulated which your Council believes should be developed as far as possible to govern such relationships, and initial steps have been taken with a view to bringing this about. "That State institutions should staff themselves to provide medical care to meet the ordinary medical needs of the institution and such special needs as the requirements of the institution would justify. Extraordinary demands beyond the abilities of the resident staff should be cared for by outside physicians recompensed upon an appropriate fee basis."† The Council is conscious of the very amicable relationships which has always existed between the state hospitals and our Society. Many physicians who have headed such institutions, have from time to time been honored with high office and responsible positions in our Society, and they have invariably served us well. Members of our association also serve on many of the boards of trustees of these hospitals, and it should not be difficult, working for the common good of the patients involved, for us to come to reasonable agreement, not only on policy but on practice.

The problem of the physician's relationship to state institutions is relatively simple, but similar more complex relationships with organized society exist in the county and the city and the town governments. Here the methods of providing medical care are as varied as could be imagined. This whole system should be closely studied by our Society. It is high time that we gave these matters our attention, for another depression may not be so far off, and it would be far better when that comes to develop existing facilities which we have had a chance to prepare in relatively good times, than to have to accept some hastily thrown together scheme in the midst of the new emergency.

Organized medicine has been suspicious of many of the plans for medical care, chiefly because the control over the practice of medicine can so easily lead to evil practices and poor care for the patient. Before we embark on any plan for underwriting medical care of the self supporting part of society, would it not seem the part of wisdom to scrutinize most carefully the methods of providing medical care

*Conn. State Medical Journal, Vol. 5:289, April, 1941.

†Conn. State Medical Journal, Vol. 5:212, March, 1941.

to those for whom society has already acknowledged its responsibility? That this care is not of good quality everywhere in Connecticut is no secret. Many of the methods used are unsatisfactory alike to patient and physician.

It will not be possible to reach the millennium when corrupt politics will play no part, but we can gain experience in providing good medical care with proper authority exercised by physicians over medical matters. It cannot be doubted that improvement in the care of the indigent will go hand in hand with a more adequate acknowledgement by organized society of the tremendous contribution made by physicians to these people. This will come to pass, however, only as the result of thoughtful study and planning by our Society. We are equipped to do this and it should be one of our early objectives.

Your Council approved the revision of the Medical Practice Act which was introduced on behalf of the Society in the present session of the General Assembly. We would call your attention to the great saving in legal fees which was accomplished in the development of this act, and our gratitude goes to the Legislative Bureau of the American Medical Association for the help which was freely given us in its preparation.

Arrangements have been completed for taking over the secretarial work of the Connecticut Board of Medical Examiners in our Society's office. Your Council thinks this is a very advantageous arrangement. Doctor Barker will be able to add these duties to his others with the aid of clerical help which will be supplied. No single function of the State Medical Society is more important than that which concerns our participation with the state government in the proper licensing of physicians and it is more than should be asked of any physician in private practice to conduct the secretariat of such a Medical Examining Board in his own office. It is highly proper and very advantageous to medical practice in this state to have this arrangement consummated.

The Council has considered carefully and urges the adoption of a by-law to create associate membership in our Society. It will surely do us no harm to have included in this list eminent scientists who are willing and anxious to be counted as our friends, and who are sympathetic with the aims and aspirations of the Society.

The Council has watched with interest the further development of post-graduate education by the Clinical Congress and it is highly appropriate at this time to take cognizance of the many years of wise guidance and leadership that Doctor Stanhope Bayne-Jones has given to his chairmanship.

The Council has participated in the preparation of plans for the Sesquicentennial Celebration at Middletown in June, 1942, and urges the House of Delegates to authorize the proposal to develop that celebration in conjunction with the annual meeting of that year.

The House of Delegates is urged to provide not more than \$2,000 for the expenses of the meeting in 1942, and it is suggested that these expenses be paid from the accumulated savings of previous years designated in the Treasurer's account as "Annual Meeting Fund."

It would seem wise that again in December, 1941, as last year, we have a special meeting of the House of Delegates, at which time the budget for the ensuing year can be

adopted and dues for membership levied. The Council believes that this pattern of two meetings a year is a good one to follow.

My report of this Council's activities would not be complete without expressing what many of you must already know, that our first full year with Doctor Barker on full time has been most successful. We hesitate to think of what this report would be like had we not had his services. He has been a spark plug to keep the engine in constant activity, and to many of the ideas which have come to successful birth, he has been not only father and mother, but obstetrician and pediatrician as well. The Council commends Doctor Barker for his efficiency and devotion, and compliments the Society on having his services.

James Raglan Miller, M.D.

REPORT OF DELEGATES TO VERMONT STATE MEDICAL SOCIETY

To the House of Delegates:

Gentlemen:

As delegates from the Connecticut State Medical Society to the 126th Annual Meeting of the Vermont State Medical Society held at Rutland, Vermont, on October 10th and 11th, the undersigned wish to report a successful and very pleasant visit.

The meetings were held at the Hotel Berwick midst most convenient and cheerful surroundings, and were conducted in a very orderly, snappy and interesting manner.

Most of the program had been arranged by the Faculty of the Rochester, New York, School of Medicine and Dentistry and covered a very general field with practical papers on varied subjects such as Pediatrics, General and Special Surgery, Infection and Radiology.

Much must be said for the manner in which the Vermont State Society entertains its medical guests and families. The banquet and entertainment are always highly interesting and amusing.

Respectfully submitted,

George Blumer, M.D.,

George A. Gosselin, M.D.

REPORT OF DELEGATES TO MAINE MEDICAL ASSOCIATION

To the House of Delegates:

Gentlemen:

The Maine Medical Association held its annual meeting at the Rangeley Lake House, Rangeley, Maine, on June 24 and 25, 1940. Both delegates from Connecticut attended the meeting. A group of papers was read the first morning, and in the afternoon a clinico-pathological conference was held. The cases discussed covered a large range, providing material among them to be of interest to every one. The same applies to the round table discussions on the second morning which covered most of the specialties, as well as general topics. In the afternoon Doctor Henry Marble of Boston was both instructive and entertaining in his talk on the early care of injuries to the hands and the scientific session ended with a demonstration of pathological specimens of various

conditions of the brain by Doctor Timothy Leary of Boston. In the evening the annual dinner was addressed by Governor Barrows of Maine and Doctor William Jason Mixer of Boston. No mention has been made of the kindly hospitality shown the various delegates by the Association and its individual members, but this is perhaps axiomatic and need not be specifically recorded.

Respectfully submitted,
Orville F. Rogers, M.D.,
Stanley B. Weld, M.D.

OUR NEIGHBORS

New Jersey

The Medical Society of New Jersey this year celebrates its one hundred and seventy fifth anniversary. In connection with this event the *Journal of the Medical Society of New Jersey* published a supplement to its April number containing a short history of the Society, a list of fellows and members, and photographs of the officers, councils, trustees, fellows and committee chairmen. In addition to the above, the supplement contains a list of members of each of the component county societies, together with the photographs of their officers.

New York

Colonel Samuel J. Kopetzky, Chief of the Medical Division, New York City Selective Service, has suggested a broadening of the Selective Service law to provide for Army controlled correction of minor physical defects of registrants who otherwise are available for full military service. The statistical report from the Selective Service showed that about one out of every four men examined by Local Board Examining Physicians in New York City are placed in Class 1-B, available for limited military service only, because of minor physical defects. Colonel Kopetzky believes that for the Army to handle these remediable deficiencies in the localities where they exist is the cheapest, safest and most expeditious way to meet this problem.

Workers caring for patients with tuberculosis can only be shielded from exposure to infection by conscious and conscientious precautions. Emil Bogen, M.D., and Wm. Dunn, M.D., *Amer. Rev. of Tuber.*, March, 1941.

OBITUARIES

Timothy Maher Ryan, M.D.
1873 - 1940

Timothy Maher Ryan was born in Tipperary, Ireland, September 15, 1873. Timothy was one of eleven children and was educated at Turley's College in Tipperary. In 1898 he came to America and continued his education at Loyola Jesuit Institute where he received the degree of B.A. In 1902 Doctor Ryan graduated from the Baltimore Medical College, magna cum laude. Following that he served an internship at St. Agnes Hospital in Baltimore. In 1903 he came to Torrington where he engaged in the general practice of medicine and soon had a large following of very loyal patients. When the Charlotte Hungerford Hospital was organized in 1917, Doctor Ryan joined the Surgical Staff and then took a postgraduate course in surgery in New York. Doctor Ryan had the privilege of performing the first surgical operation at the hospital. He assumed the responsibility of three months ward surgical service and held that position until 1938 when he resigned because of poor health and accepted a consultant service.

During the first World War, Doctor Ryan acted as a member of the Medical Exemption Advisory Board. For ten years he served on the Board of Education, three years was Fire and Police Surgeon and for a long term a Railroad Surgeon. Doctor Ryan was an active member of the Democratic Town Committee. His many social attributes led him to the classification of "Joiner." He was a member of the Elks, Knights of Columbus, Foresters of America, Ancient Order of Hibernians. He also belonged to the Society of Friends of Irish Freedom, the American-Irish Historical Society and the Sons of St. Patrick. He joined the Litchfield County University Club. He was also an active member of the Litchfield County Medical Association and its president in 1931.

Doctor Ryan was a well informed, brilliant speaker and had a great sense of humor. It may well be said that we who had the opportunity of knowing Timothy Ryan and working with him were truly fortunate. Doctor Ryan departed from this world December 16, 1940, but his influence remains with us.

Harry B. Hanchett, M.D.

SPECIAL NOTICES

1941 GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE

The Graduate Fortnight of The New York Academy of Medicine will be held from October 13 to 24, 1941.

The purpose of the Fortnight is to make a complete and authoritative presentation of a subject of outstanding importance in the practice of medicine and surgery. The subject this year is Cardiovascular Diseases Including Hypertension.

The Fortnight will present a carefully integrated program which will include morning panel discussions, afternoon clinics and clinical demonstrations at hospitals of New York City, evening addresses, and a scientific exhibit. The evening sessions at the Academy will be addressed by recognized authorities from leading medical centers of the United States and Canada. The comprehensive exhibit will include books and roentgenograms; pathological and research material; clinical, laboratory, diagnostic and therapeutic methods. There will be demonstrations of exhibits and of fresh pathology.

The evening lecture program follows:

Basic hemodynamic principles essential to interpretation of cardiovascular disorders, Carl Wiggers, Cleveland.

Heart failure, Paul D. White, Boston.

Diagnosis and treatment of coronary insufficiency, Robert L. Levy, New York.

Pathology of arteriosclerosis, with special reference to coronary arteries, Timothy Leary, Boston.

Observations on social significance and recent advances in the treatment of arteriosclerosis, George Morris Piersol, Philadelphia.

Advances in our knowledge of endocarditis—with special reference to the therapy of subacute bacterial endocarditis, Emanuel Libman, New York.

Neurocirculatory asthenia and related problems in military medicine, B. S. Oppenheimer, New York.

Syphilis of the cardiovascular system, Edwin P. Maynard, Jr., Brooklyn.

Arrhythmias including paroxysmal tachycardia and their treatment, Isaac Starr, Philadelphia.

The value and limitations of the electrocardiogram in medical practice, H. M. Marvin, New Haven.

Evaluation of drugs used in the treatment of cardiovascular diseases, Arthur C. DeGraff, New York.

Surgery of the heart and large vessels, Edward D. Churchill, Boston.

Surgical treatment of peripheral embolism and peripheral aneurism, Gerald H. Pratt, New York.

Thrombophlebitis, Irving Wright, New York.

Heparin, D. W. Gordon Murray, Toronto.

Raynaud's disease, James C. White, Boston.

Thromboangiitis obliterans, Edgar V. Allen, Mayo Clinic.

Experimental studies related to shock, Magnus I. Gregersen, New York.

Influence of extrinsic factors on the coronary flow and the clinical course of heart disease, N. C. Gilbert, Chicago.

Treatment of heart disease in childhood, T. Duckett Jones, Boston.

Management of heart disease in pregnancy, Harold E. B. Pardee, New York.

Mechanism of essential hypertension, Harry Goldblatt, Cleveland.

Mechanism and treatment of pulmonary edema, Soma Weiss, Boston.

Rheumatic heart disease, Alfred E. Cohn, New York.

Effects of renal extracts on hypertension, Tinsley R. Harrison, Nashville.

Members of the medical profession are eligible for registration.

A complete program and registration blank may be secured by addressing: Doctor Mahlon Ashford, The New York Academy of Medicine, 2 East 103rd Street, New York.

EXAMINATIONS AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Cleveland, Ohio, by the entire Board from Wednesday, May 28, to Monday, June 2, 1941, inclusive, prior to the opening of the annual meeting of the American Medical Association in Cleveland.

The Board requests that all prospective candidates who plan to submit applications in the near future request and use the new application form which has this year been inaugurated by the Board. The Secretary will be glad to furnish these forms upon request, together with information regarding Board requirements. Address Doctor Paul Titus, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

This Board will hold its annual dinner for Diplomates, and others interested in the work of the Board, on Wednesday evening, June 4, 1941, at the Wade Park Manor Hotel, Cleveland, Ohio, immediately following the close of the Part II examinations. Diplomates certified at the preceding days' examinations will be introduced personally, and there will be several speakers.

Tickets at \$3.25 each may be obtained from Doctor Joseph L. Baer, chairman, 104 South Michigan Avenue, Chicago, Illinois, or at the Registration Desk during the examination period.

DIRECTORY OF MEDICAL SPECIALISTS 1942 EDITION

Specialists eligible for listing in the forthcoming second edition of the Directory of Medical Specialists are urged

to fill in and return promptly the questionnaires for biographic data now being mailed out by the publication office.

This Directory is the official publication of the Advisory Board for Medical Specialties, issued every two years, and listings are limited to those formally certified by any of the fifteen American Boards examining in the medical specialties. There is no charge for such listings.

The second edition is now being prepared, and will be ready for distribution early in February, 1942, with biographic, geographic, and alphabetic listings of all diplomates certified to January 1, 1942. It will include approximately 18,000 names.

The Directing Editor is Paul Titus, M.D., 1015 Highland Building, Pittsburgh, Pennsylvania, and the secretaries of the fifteen American Boards constitute the Editorial Board.

MICHAEL REESE HOSPITAL Cardiovascular Department

Offers a Full-time Intensive Course in
Electrocardiography

Two Weeks, August 18 — August 30, 1941

By Doctor Louis N. Katz

Director of Cardiovascular Research

This is an intensive course offered to the general practitioner. There will be practice on several electrocardiographic machines and discussion of the principles of their construction and use. There will be sessions on interpretations of electrocardiograms illustrated by lantern slides, and practice by the student with unknown records. Routine

records taken during the time of the course will be discussed. Emphasis will be placed on chest leads and on the importance of the electrocardiogram in coronary sclerosis and myocardial infarction. The mechanism and interpretation of heart irregularities will be developed.

As group and individual instruction will be given, the course is open to both the beginning and advanced student in Electrocardiography. It is planned to individualize the course so that at the end of the period each student will be capable of taking and properly interpreting routine electrocardiograms. In order to accomplish this purpose the class will be limited in number. It is imperative, therefore that reservations be made early. An hourly program of the course will be sent on request.

For further information address:

Michael Reese Hospital
Cardiovascular Department
29th and Ellis Avenue
Chicago, Illinois

COURSES IN OBSTETRICS

The Illinois State Department of Public Health and the Childrens Bureau, U. S. Department of Labor are sponsoring ten 4-weeks courses in obstetrics at the Chicago Lying-in Hospital during the fiscal year 1941-1942. Only a limited number of physicians will be accepted for each course. The only cost to the individual is for room and board and \$25.00 (\$10.00 of which is refunded at the completion of the course). Applications and inquiries should be addressed to: Postgraduate Course, Department of Obstetrics and Gynecology, 5848 Drexel Avenue, Chicago, Illinois.

The Barker Commission

The report of "The Commission on the Treatment and Care of People Afflicted with Physical or Mental Disabilities," commonly known as the Barker Commission, is at hand. This Commission was created by the passage of Special Act 548 by the General Assembly of 1939. The Commission as it finally was formed consisted of Creighton Barker, M.D., Chairman, Wilmar M. Allen, M.D., Joseph B. Downes, Ira V. Hiscock, and Lucius F. Robinson, Jr., with William H. Coon, M.D., Coördinating Director.

Because of its thorough investigations with their

far reaching effects, especially as they are related to the Norwich State Hospital, the Commission received considerable publicity in the press. Its work was monumental and characterized by a thoroughness commendable in its detail. The recommendation concerning appropriations to hospitals, designed to meet expenses incurred in the care of charity patients, is but one example of many wise and timely recommendations made by this Commission. The Executive Secretary of the State Medical Society deserves much credit for many hours of thoughtful effort on behalf of the citizens of our State.

WEATHER MAKER: — There is now available a perfected and easily installed air conditioner which will really cool the doctor's office at a very nominal cost. Simply plug it in and it will cool, filter, dehumidify, change, and circulate the air. The Professional Equipment Company of New Haven is Connecticut's distributor to doctors.

(SEE PAGE 2)

THE FORUM

Dear T. P. R.:

Our results with Vitamin E in the muscular dystrophies and scleroses have been disappointing. We tried both the synthetic and natural products, alone and in combination with factors of the B complex, without appreciable result. We also found it to be almost as useless in the treatment of habitual or threatened abortion. With one definite exception, we have not been able to prove any relationship between sex hormones and cancer; the exception is cancer of the breast in women. Since the estrogens stimulate circulation and engorgement in breast tissue, all women who receive this therapy must have a negative family history of breast cancer plus an adequate investigation of suspicious nodules. We have found that this treatment also aggravates the so-called painful breast. We have had better luck with testosterone in this condition, but it must be used in small doses in order to prevent the development of male characteristics. We have used stilbestrol in the treatment of the menopause, but because of some unpleasant gastro-intestinal disturbances, I can't give you anything definite on it. Arthritis is still the subject of much discussion around here. We are trying out a new gold compound in some selected cases. The results are good but we don't know too much about possible toxic effects. Another series of cases is being handled by our psychiatric department in close coöperation with the social service, the rationale being that many of these patients are emotionally and socially mal-adjusted. I'll have more details about it later on. I canvassed the men in the skin clinic for something new on psoriasis. They have been assigning the cases as they come in, without selection as to severity, into three treatment groups. The first is using intramuscular injections of manganese (colloidal) and the patient's blood;—10 cc. of blood is taken from the patient's arm, to this is added 1 cc. of the man-

ganese and the whole is injected into the buttock. This procedure is repeated every fourth day. The second group is using large doses of vitamin B complex supplemented with brewer's yeast. The third uses daily hypodermic injections of nicotinic acid and pyridoxine (B6). In all cases local treatment is limited to soothing applications. Of the three, the best immediate results occur in the first group, but the third is close behind. Our neurological surgeons strongly advise against the use of morphine in head injuries and in cerebral hemorrhage, not only does it mask the symptoms but it actually causes a marked increase in the intracranial pressure. They also condemn indiscriminate spinal taps. Treatment here, although fairly well standardized, is adaptable to most cases. The patient is constantly watched and except for essential procedures is not disturbed. Restlessness is controlled with chloral hydrate, paraldehyde or one of the many barbiturates. Intracranial pressure is kept down with intravenous injections of caffeine-sodio-benzoate, rectal instillations of strong black coffee and fluid restriction. Hypertonic salt and glucose solutions are occasionally used but they are not as efficient as the caffeine. The men here are quite satisfied with the results of x-ray treatment for carbuncles and furuncles, especially those involving the face and neck. The relief from pain is usually prompt, scarring is eliminated and depilation has proven to be a temporary thing. X-radiation is also proving to be a valuable agent in treating the acute bursitis. Here again relief from pain is prompt. In the chronic form it hasn't done so well. In these cases, we usually resort to "needling," multiple punctures of the bursa. We are still on the fence about the several vitamin B's. Our results with them certainly do not compare with those of other investigators, and there is a definite and growing skepticism about some of the claims made for them. We have been fortunate in having a special fund to cover the research, otherwise we could not carry on, due to the prohibitive cost of some of the individual components.

Best O' Luck,
Gregg.

SHOE FITS; PUT IT ON! — For the first time there is a shoe especially designed to provide a practical and comfortable covering for swollen, tender, or bandaged feet. "Mollo-pedic" shoes are easily adapted to various sizes of plaster casts or bandages on either foot. They afford proper support, yet are soft and flexible. A real pleasure to the patient, "Mollo-pedic" shoes truly protect. \$1.50 at the Professional Equipment Company in New Haven.

NEWS *from County Associations*

Fairfield

Doctor C. F. Yeager, Medical Supervisor of the Remington Arms Co., Bridgeport, addressed the Twelfth Annual Convention and Exposition of the Greater New York Safety Council, Inc., in New York City on April 24. Doctor Yeager spoke on the industrial health program in national defense.

On May 6 Doctor Louis H. Clerf, Professor of Bronchoscopy at the Jefferson Medical College spoke to the Bridgeport Medical Association on the subject of "Certain Symptoms and Signs of Bronchopulmonary Diseases Viewed Bronchoscopically." The paper was well presented and enthusiastically received.

On Tuesday, May 13, the combined meeting of the Stamford and Greenwich Medical Societies was held at the Stamford Hospital to discuss Sulfadiazine. R. O. Roblin, PH.D., who helped to develop the chemical compound, discussed the "Chemistry of Sulfadiazine." W. Harry Feinstone, SC.D., who did the original animal experimentation, spoke on "Toxicity—Absorption and Chemo Therapeutic Activity of Sulfadiazine." Doctor Joseph Sadusk, Jr., discussed the early experimental use of this drug in man and outlined the results in treating pneumonia and other types of infection at the New Haven Hospital. Doctor Harold L. Amoss presented a "Survey of Literature on Sulfadiazine." Following these papers cases from the Stamford and Greenwich Hospitals were reported which had been treated with sulfadiazine. This was a very timely and extremely valuable meeting.

As this news goes to press notice is received that Doctor Fenwick Beekman, Professor of Clinical Surgery at Bellevue, will address the Stamford Medical Society May 21 on the subject "Management of Acute Appendicitis and its complications."

National Hospital Day was celebrated throughout Fairfield County on May 12 as in the rest of the country. St. Vincents Hospital had special visiting hours, as did Bridgeport Hospital. On Sunday, May 11 the Directors, the Medical Staff and Nurses of Bridgeport Hospital participated in the annual hospital day service at the United Church.

Hartford

Newington has been conducting a tuberculosis case finding survey during the past year. Out of a population of 54,446 a total of 29 cases were found with 109 additional contacts. The total cost of the survey was \$202.27. This low figure was made possible by the proximity of Cedarcrest Sanatorium where the x-rays were taken; donated services of a local nurse, a field worker from the National Tuberculosis Association and a medical consultant from the State Tuberculosis Commission.

The Hartford Eye, Ear, Nose and Throat Society held a dinner and meeting on Wednesday, May 7, at the Hotel Heublein. The business part of the meeting started at 7:00 P. M. and following the dinner there was a symposium on Head Injuries. Doctor W. D. Scoville discussed the neurological aspects, Doctor Dewey Katz the ophthalmological and Doctor Edward Whalen the otolaryngological. Twenty four members and several guests engaged in a round table discussion.

The officers of this Society are Doctor Walter Hogan, President, Doctor Joseph Kilbourne, Vice-President and Doctor Milton Little, Secretary.

After many years of service as Librarian of the Hartford Medical Society, Doctor Walter R. Steiner has resigned this post and is now Librarian Emeritus with Doctor Ernest Caulfield as Librarian and Doctor Louis F. Middlebrook, Assistant Librarian.

Doctor Charles C. Wilson has just announced his resignation as director of health for the City Schools of Hartford, to accept a professorship at Teachers College, Columbia University. Aside from his work in the Hartford Schools, Doctor Wilson has been active in national and state health organizations. He is President of the Hartford Tuberculosis Society and Vice-President of the Connecticut Tuberculosis Association.

Doctor William R. Hanrahan of Bristol is the new vice-president of the Hartford County Association and not Doctor William F. Flanagan as was incorrectly announced in the May number of the *Journal*.

Litchfield

The 177th annual meeting of the Litchfield County Medical Society was held on Tuesday, April 29, at the Litchfield County Hospital, Winsted. About 40 physicians attended the opening luncheon which was followed by a reception to the visiting

delegates. Doctor Arthur Landry, President of the Connecticut Medical Association, and Doctor Fred Sperry, President of the New Haven County Medical Association, spoke. A resolution upon the death of Doctor Timothy M. Ryan of Torrington was adopted. Mr. Herbert Morford, recently appointed Superintendent of the Litchfield County Hospital, was introduced to the members of the Association and spoke briefly. President Roy V. Sanderson of Winsted presided over the meeting. He chose as the subject of his address, "Society and Public Sentiment" in relation to the physicians. Doctor W. C. Hall of Hartford addressed the group on the subject of "Roentgenology of the Heart."

The following officers were elected for the ensuing year: President, Herbert C. Oelschlegel of Torrington; Vice-President, Robert Sellev, Sr., of Canaan; Secretary and Treasurer, W. Bradford Walker of Cornwall; Councillors, Frederick W. Wersebe, H. B. Hanchett, Jerome Chaffee; Censor, R. V. Sanderson; Committee on Ethics and Deportment, H. B. Hanchett, Jerome Chaffee, Elias Pratt, Winfield E. Wight and Charles H. Turkington; Committee on Public Policy and Legislation, Brigadier General Sanford H. Wadhams, Elias Pratt and C. A. Turkington; State Delegates, W. E. Wight and F. A. Sutherland.

Doctor Charles Y. Bidgood, Consultant in Urology at the Charlotte Hungerford Hospital, was ordered to report on May 19 to the Commandant of the 3rd Naval District for active duty. Doctor Bidgood holds the rank of Lieutenant Commander in the Medical Reserve Corps of the United States Navy.

Doctor Frank M. Polito recently spent two weeks at Pinchurst, North Carolina, acquiring a heavy coat of tan and a reputation as an expert golfer.

A gold badge was presented to Doctor F. L. Polito, recently appointed police and fire surgeon, at an informal reception held in his honor at the fire house. The badge, which was purchased by the Firemen's Association was presented by Mayor William A. Patten. Doctor Polito succeeded the late Doctor T. M. Ryan as police and fire surgeon.

Among the physicians in Litchfield County who attended the annual meeting of the American College of Physicians held at Boston in April were Louis E. Garston, Charles H. Turkington and W. Bradford Walker.

Middlesex

Newly elected officers of the Middlesex County Medical Society are: President, Harry S. Frank; Vice-President, Edgar Fauver; Clerk, Charles Russman; Councilor, A. N. Sweet.

Doctor Anna Dengal, a medical mission sister addressed the Central Medical Society on May 12. Her subject was "Medical Work In India."

Doctor F. Erwin Tracy of Middletown was recently enrolled in a medical course given under the auspices of the American College of Physicians in Boston.

Doctor Harold E. Speight of Middletown has been notified of his certification as a Diplomate of the American Board of Internal Medicine.

A daughter, Linda Diane, was born on May 10 to Doctor and Mrs. Benjamin Roccapriore of Middletown.

New London

Doctor Harold Higgins of Norwich has been appointed consulting Obstetrician and Gynecologist to the Norwich State Hospital.

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Doctor Harold Bergendahl of Taftville has been appointed Medical Officer for the State Home Guard in Norwich.

The W. W. Backus Hospital of Norwich has purchased a modern three patient ambulance, thus assuring Norwich and its surroundings excellent added service.

Doctor Alfred Labensky, New London, was elected a Fellow of the American College of Physicians at the April meeting held in Boston.

Doctor Lawrence Ward, New London, has been certified by the American Board of Internal Medicine as a specialist in internal medicine and cardiovascular disease.

Doctor James P. Moran, New London, U. S. N., (R), M. C., Lt. (J. G.), has been ordered to report for active duty at the Submarine Base Naval Hospital, New London, May 12, 1941.

The final spring meeting of the New London County Medical Association will be held at the Norwich Inn, Norwich, Thursday, June 5. The scientific session will feature a symposium on "Low Back Pain." It will be a Hartford night with all the speakers from Hartford.

G. A. Gosselin—Neurologist
S. H. McPherson—Orthopedist
C. Y. Bidgood—Urologist
H. G. Thompson—Gynecologist

Dinner will be served at 6:30 P. M., the business meeting to follow the dinner. The symposium is scheduled for 8:30 P. M. A cordial invitation is given to all practitioners in this vicinity to join in this interesting discussion.

Doctor Hugh B. Campbell, superintendent of Uncas-On-Thames, is one of the Committee of

Judges for the Tuberculosis Essay Contest among Negro high school students in Connecticut. The subject of the essays will be the "Why, What and Where About Tuberculosis," and will be limited to 2,000 words written by Negro high school students in grades nine to twelve. National prizes will include a \$100 scholarship at any Negro college, plus a handsome gold medal, and thirteen other cash prizes ranging from \$40 to \$5 each.

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Tolland

The regular semi-annual meeting of the Tolland County Medical Association was held April 15 at Somers, with President William Schneider in the chair. Doctor Arthur B. Landry, President of the State Society, spoke briefly on the possibility of lower dues for new members, the importance of industrial medicine, and the projected formation of a general practitioners' section. Doctor James R. Miller sketched the activities of the Council, and read a letter from Eire that was almost too good to be bona fide. Doctor Creighton Barker then indulged in some reminiscences and anecdotes. Delegates from other counties were presented, including the perennial Doctor William H. Upson of Suffield. The speaker of the evening was Doctor Orpheus J. Bizzozero of Waterbury, whose topic was "The Clinical Aspects of Ovarian Hormones." Following this, a new slate of officers was elected, with Doctor Walter C. Haviland of Mansfield as President.

Since March 1940, Miss Margaret E. Fay has been full time laboratory technician at the Rockville City Hospital. Miss Fay took her preparatory training with Doctor C. L. Overlander at the Sias Laboratories, Brooks Hospital, Brookline, Mass., and previously to accepting her present appointment had served in the New Britain Hospital and had done work for private physicians. New and very satisfactory facilities were provided at the time for all routine work except bacteriological cultures, and so a step forward is taken by the hospital and its appreciative staff.

A garage is under construction at the Rockville City Hospital to house the new two-patient Henney ambulance recently acquired by the hospital, both filling long-felt local needs.

Occupational Dermatoses

The ideal method of preventing occupational dermatoses is to totally enclose all industrial processes where known skin irritants are present. This is not always feasible, however, and it is then necessary to devise methods to prevent the irritants, in so far as possible, from coming in contact with the skin of the workers. Suction exhaust apparatus can be used to remove irritant dusts and fumes. Protective clothing such as gloves, sleeves, aprons, cover-alls, boots, etc., made of material impervious to the

particular irritant encountered, can also be used to protect the workers.

Protective ointments have a place in the prevention of occupational dermatitis in the new worker, during the period when his skin is becoming accustomed to the new working conditions. Protective ointments may be useful also for specific purposes, such as protecting the skin from fat solvents, or they may be used as a vehicle for bland chemicals that will neutralize known irritant chemicals. The use of protective ointments, however, is not a substitute for the more certain and the more effective methods previously described.

Cleanliness of the worker's person, his work clothes, and his environment is, of course, fundamental to the prevention of industrial dermatoses.

The treatment of industrial dermatoses is essentially that for acute, subacute and chronic eczemas from any cause. Only the mildest forms of lotions and ointments should be used. New workers with mild dermatitis may be able to return to their former occupation after recovery if they take proper precautionary measures until they become "hardened." Those severely affected have no recourse but to change their occupation to one where they do not encounter the material responsible for their dermatitis.

From a paper presented by Louis Schwartz, M.D., before postgraduate course in Industrial Medicine, Connecticut State Medical Society, New Haven, 1941.

GASTRO-INTESTINAL DISTURBANCES IN NERVOUS AND MENTAL DISEASE

(Continued from Page 428)

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QUARTO NOTES

ELECTROCARDIOGRAPHY IN PRACTICE. By Ashton Graybill, M.D., Instructor in Medicine, Courses for Graduates, Harvard Medical School, and Paul D. White, M.D., Lecturer in Medicine Harvard Medical School. Philadelphia: William B. Saunders Company. 1940. 319 pp. Illustrated. \$6.00.

Reviewed by PETER J. STEINCROHN, M.D.

"The importance and value of electrocardiography need no longer be emphasized. Although introduced as an aid to the understanding of the cardiac arrhythmias, its usefulness has been extended to far more important disorders of the heart. It is therefore no exaggeration to say that electrocardiography has proved indispensable to the proper handling of many patients with heart disease."

The above quotation, lifted from the authors' preface, again stresses the need for an understanding of electrocardiography by the physician who treats the cardiac patient. Doctors Graybiel and White might well have said that this procedure is indispensable to the proper handling of *most* patients with heart disease.

Electrocardiography is also exceptionally important in the sphere of Preventive Medicine. It is not unusual to discover evidence of myocardial damage despite absence of clinical symptoms and physical signs.

This volume is well bound and set up. Its index is complete and helpful. The main body of the work consists of two parts.

Part I:—*The Electrocardiogram of the normal heart, of the heart in disorders of rhythm and in the etiologic types of cardiac disease.*

In addition to a presentation of the usual etiologic factors, there is discussion of the electro-cardiographic changes in: Trichiniasis, Trypanosomiasis, Parathyroid disease, Addison's disease and Trauma.

Part II:—*Electrocardiograms for practice in interpretation.*

About one-half of the book's tracings serve the purpose of weaning the reader away from 'easy' interpretation. A diagnosis and discussion of these practice electrocardiograms is given on a page opposite the tracing—thus giving the student the opportunity to first make his own diagnosis.

This feature is highly commendable.

The volume ends with an "analytical electrocardiographic index" which summarizes the clinical and pathological findings associated with abnormalities of the various complexes.

"Electrocardiography in Practice" is recommended as an excellent addition to the growing literature on this subject.

Table of Contents : July 1941

ORIGINAL PAPERS

INDUSTRIAL MEDICINE	Arthur B. Landry, M.D., Hartford	481
EARLY MEDICAL PRACTICE IN HARTFORD COUNTY	Stanley B. Weld, M.D., Hartford	484
DIET AND BRIGHT'S DISEASE	Soma Weiss, M.D., Boston	496
GASTRO-INTESTINAL SYMPTOMS IN EYE, EAR, NOSE AND THROAT DISORDERS	Shirley Harold Baron, M.D., New London	502
DIAGNOSIS OF CANCER OF THE STOMACH AND COLON	A. W. Oughterson, M.D., New Haven	506
CLINICAL CONSULTATIONS AND HOSPITAL CARE SERVICES IN A MATERNAL AND CHILD HEALTH PROGRAM	Martha L. Clifford, M.D., Hartford	510

EDITORIAL

A New Leader	517	Prenatal Blood Test Law	519
Connecticut Again Leads	517	Doctor Klumpp Goes to A. M. A.	520
Doctor Osborn Succeeds Himself	518	Another Clinical Congress Approaches	520

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	523	OUR NEIGHBORS	543
CONNECTICUT HOSPITAL ASSOCIATION	528	NEWS FROM COUNTY ASSOCIATIONS	543
MEDICAL PREPAREDNESS	532	THE DOCTOR'S OFFICE	544
THE LEGISLATURE	535	THE FORUM	545
INDUSTRIAL HEALTH	538	QUARTO NOTES (Book Reviews)	550

MISCELLANEOUS

DANBURY HONORS DAVID CHESTER BROWN	521	17TH CLINICAL CONGRESS PROGRAM	513
YALE DEDICATES NEW MEDICAL LIBRARY	522	ANNUAL REPORTS	541
AMERICAN MEDICAL ASSOCIATION IN CLEVELAND	525	OBITUARIES	546
		SPECIAL NOTICES	548
		OFFICERS AND COMMITTEE CHAIRMEN	
		Connecticut State Medical Society	4
		Connecticut Hospital Association	4

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The CONNECTICUT STATE MEDICAL JOURNAL

VOL. V

JULY, 1941

No. 7

INDUSTRIAL MEDICINE

ARTHUR B. LANDRY, M.D., *Hartford*

TODAY I CHOOSE to speak to you on "Industrial Medicine." I do not speak as one specially trained in this field but rather as one interested in the development of an old subject which has reached a position of great importance in modern society with increasing repercussions upon the general practice of medicine.

Although occupational diseases were recognized in miners, fullers, and chemists by Hippocrates and Galen, little was known beyond their occurrence. It was not until Bernardino Romazzini's treatise on "Diseases of Tradesmen" was published in English in 1793 that the hazards of one hundred different occupational diseases were described and their prevention and treatment discussed. Prior to that, during the days of the craft guilds in the 14th Century, labor was organized for the protection and regulation of trades, and the physical and social welfare of artisans was supervised. But organized medical supervision was not then practiced. With the advent of the machine age, there began a recession in the protection of workers in industry. Operatives worked in the mills, machinery replaced hands, and often children succeeded adults in the cotton mills in the North of England. Unhygienic and often hazardous conditions prevailed.

In 1796, the Factory Act was passed limiting the hours of employment of the young and providing for arrangements for their education and also for professional inspection of factories and the enforcement of sanitary legislation. This was followed in 1844 by the Children's Half-time Act which not only limited their working hours to 6½ a day but provided, as well, for their protection against injury from dangerous machinery. This Act also provided for the reporting and care of accidents in industry.

In 1848, the British Parliament created the Central Office of Public Health which at once began the

study of methods of combatting disease among factory workers.

In France, it was not until 1822 that the Consulting Committee on Public Hygiene, succeeding less active organization, began to foster the study of occupational diseases in silk, wool, tobacco, and rubber industries. The founding of the International Association for Labor Legislation in Paris in 1900 marked the beginning of a more coherent program.

The United States has lagged in the matter of labor legislation. In 1852, the first state law pertaining to the protection of workers in industry was passed by Massachusetts. This same state, in 1877, provided for the inspection of factories, and ten years later the law was further modified to include sanitary and hygienic provisions. Real advancement came in 1912 with the enactment of Workmen's Compensation Laws in certain of the states. Forty-seven states now have compensation laws for industrial accidents, and twelve states also provide for compensation for occupational diseases.

It must be remembered that health reforms in industry have been brought about through the efforts of many individuals and agencies. Labor, the professions, legislators, social organizations, industrialists, and insurance carriers—all have had their part in the evolution of what is now called Industrial Medicine.

The greatest help in the prevention of industrial accident and occupational diseases came from the scientific activities of bureaus of occupational diseases, usually within State Departments of Health. Such bureaus are now established in twenty-seven states. They inspect industrial plants, study the health hazards, and make recommendations.

Industrialists, too, are becoming health minded. In many plants, physicians, nurses, together with chemists and factory engineers, are employed in the

Address by the President, Connecticut State Medical Society, delivered at the 149th Annual Meeting, Bridgeport, May 21 and 22, 1941

all important task of health conservation. Organized medicine, though tardily, has taken up the matter of promoting the study of industrial hazards, the teaching of industrial medicine, and the establishing of standards of medical service in industry.

In 1926, the American College of Surgeons appointed a committee on Traumatic Surgery. On this committee were representatives of the College, of medical departments of insurance carriers, and of industrial organizations. The purpose of this committee was to study the whole program of traumatic surgery. Finally, after investigation and research, the committee founded a standard of medical services which is applicable to all industrial organizations regardless of size. In 1931, the practical application of this standard was begun by the College. In October 1939, 1,782 industrial establishments representing 6,000,000 employees had been surveyed. Of this number of plants, 922, or 52%, had been fully or provisionally approved.¹

The Council on Industrial Health of the American Medical Association was created in 1937 to prepare the profession for its duties toward the industrial worker; and today there are 34 State Societies studying the problems of industrial health. When we come then to present-day Industrial Medicine, we find ourselves in the presence of a growing complexity. We also find ourselves in the presence of a growing social awareness and concern seeking guidance and direction. The whole social movement gives promise of better things to come.

A precise definition of industrial medicine is difficult. The field is now so broad that it embraces many sciences and involves numerous agencies—governmental, social, and economic. If we accept in this connection the dictionary definition of industry as “useful labor in general,” we approximate the extent to which our subject is applicable. Industrial medicine has been defined as: the science and art which deals with the prevention, cure, and alleviation of disease as it affects gainfully employed individuals.²

A clearer understanding of industrial medicine may be arrived at by looking at some of its objectives as stated in an editorial of the A. M. A. Journal of January 4, 1930:

1. To fit every person to types and quantities of work according to his ability to perform such work continually without undue impairment, without injury to himself and his employer;
2. To procure and maintain fitness for work

through efforts applied to the worker as an individual;

3. To educate the worker to a comprehension of the value and significance of physical and mental well-being and, in particular, of personal hygiene and accident prevention;
4. To reduce all loss of time, absenteeism, and short-work spans in industry, the cause of which may be related in any way to health.

An earlier concept confined the practice of industrial medicine to prevention, alleviation, and cure of diseases arising only under employment. This has been greatly changed. Now the aim—properly to fit individuals to types of work and to maintain them in good health during employment—encompasses the whole realm of medicine. Thus, industrial medicine has developed into a special field requiring skillful direction and the adaptation of good medical practice to sound economic and social principles. And the interrelation, as well as the coöperation, of employees, employers, attending agencies, specialists, and family physician must be welded and harmoniously guided by a competent director. Fortunately members of the medical profession have risen to the occasion and through special training have qualified admirably for the leading role of director or administrator. So that, today, doctors known as industrial physicians head the medical departments of industrial organizations. No longer will these physicians of high standing and importance be regarded as failures in general practice taking refuge in full-time employment that formerly seemed unessential—beneath the dignity of the private practitioner. The position of the industrial physician is secure and is now raised to a commendable level. A physician thus engaged must have special qualifications. He must have not only knowledge of the work at hand, but also the talent for administrative ability coupled with sympathetic understanding. He must have high ideals regarding the laborer's position in society. He must be motivated by a profound concern for the advancement of his special field. This physician holds a key position in safeguarding the health of the community and must now be looked upon as an important member in our complex society.

The exercise of his office should add to the comforts, pleasures, and earning capacities of individual workers. His task is difficult and often misunderstood. His, as well as the general practitioner's, obligation is first to the worker and his protection against the hazards of industry. He occupies a rather

singular position in relation to the family physician. He is the one who will be looked upon as the counselor of the employee in matters pertaining to health, and his advice may often be sought regarding the health of the employee's family. Diplomatic discretion, wisdom, and, above all, forthright honesty must direct his course.

Allusion has already been made to the Bureaus of Occupational Diseases within the State Departments of Health, which have taken such an active part in the prevention of occupational diseases and in the minimizing of mechanical hazards in industry. I cannot overemphasize the aid which they are in a position to render to those engaged in the practice of industrial medicine. Through their well-trained specialists and investigation facilities, they can and do apply research methods to the difficult problems of industrial medicine which, by their complex nature, are quite beyond the means of the small industrialist and the general practitioner to solve.

Connecticut is fortunate in its State Department of Health. Here we have an efficient Bureau of Occupational Diseases dealing with the study of problems arising under industrial conditions and making sound recommendations to safeguard the health of employees. Here, too, is a Bureau which holds consistently to its definite function of research and preventive medicine. Be well assured that, as time goes on and the ever-widening circle encompasses every industry, the service of this fine Bureau will be increasingly used and appreciated.

The specialist, as well as the general practitioner, is engaged in the field of industrial medicine. Their sphere of activity should be analogous to that of private practice with such limitations, in either instance, as custom and good medical care demand. No compensation law nor industrial plant regulation should influence either to sway from the rules which govern the practice of medicine in general.

To be sure, compensation laws and plant regulations must be respected; but the procedure for referring cases and preventing encroachment upon one another's practice must be in accordance with the principle of sound practice and never have the semblance of "lifting" cases.

The question of free choice of physician on the part of the employee is still a controversial subject. A limited free choice, by which we understand the choice made from a given panel of physicians, is rapidly coming into common use. Perhaps the panel system will ultimately best serve the purpose of giving the employee the best medical services avail-

able and so will come into general acceptance.

It is obvious that general practitioners must be included in the panel system. Surely, with the splendid medical and surgical training with which the general practitioner starts out in medicine, he is competent to take care of a large group of medical and surgical cases in industry. Then, too, in small plants he may be the only one available for industrial medical practice. In any event, the plant physician, whether specially trained as such or a general practitioner, has grave responsibilities to the employer, employee, insurance carriers, and to his fellow practitioners. His best work will be done through conscientious discharge of his duties in consultation with all concerned.

Industrial Medicine is here to stay, and its present pattern marks one of significant social and medical advances in which the medical profession may take just pride. It will improve as medicine progresses; and as its members are kept abreast of its development, more time will have to be devoted to this subject in our medical meetings and in our medical schools.

The laboring man has fought hard for better working conditions, and the day has come when his efforts are being rewarded. Laborers—all laborers, men and women—are entitled to the conservation of their strength and health during the days of their working capacity. They are entitled, also, to the extension of these working days over a longer number of years through the elimination of employment hazards, the prevention of disease, as well as early and proper treatment of unavoidable illnesses incident to their occupation. All this is the high objective of Industrial Medicine. By protecting the health of the laborer, keeping him physically fit, it should not be too difficult to maintain a level of industrial productivity which will not only satisfy the employer but keep the laborer self-sustaining in abundance and security. Much, indeed, has already been written on the subject, but the full value of this protection has not yet been estimated. We await another glorious page in the annals of medicine which will some day be written on the advances made to protect the health of labor.

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EARLY MEDICAL PRACTICE IN HARTFORD COUNTY

STANLEY B. WELD, M.D., *Hartford*

A GENTLE WESTERLY breeze wafted in from the low lying hills blows through the sails of the Dutch ship *Onrust* as it threads its way northward from the Sound along the Vershe River. Described by the historian Scaeva as a little yacht of sixteen tons, it, nevertheless, measures forty-four and a half feet long and has served well its captain, Adriaen Block, on his voyage from Manhattan Bay eastward along the coast and now northward as he ventures inland. To his credit may be ascribed already the discovery of Block Island, and now as summer gives hint of fading he seeks new lands. With him is Skipper Cornelis Hendricxsen, his first mate, and together they guide their craft up the river to the head of navigation, a point later known as Enfield Falls, located at Warehouse Point. Retracing their course, they drop back down the river a few miles and beach the *Onrust* on the west bank, to set up the flag of the Netherlands at what is now known as Dutch Point.

This was the year 1614. Not till nineteen years later did these hardy pioneers build their fort, the *House of Hope*, and then not until rumors of the coming of the English made some sort of protection seem necessary. No record can be found of any physician, barber-surgeon, or alchemist among these first settlers nor do we find that the band of Plymouth colonists sailing up the river past the Dutch fort to settle Windsor numbered among its flock anyone who knew anything of the care of the sick. Pestilence, probably smallpox, appeared among the Indians soon after the first band of white men settled Windsor in 1633-4. Most of the Indians are said to have died but "no one of the English was so much as sick."

In 1636 when the first organized attempt at a settlement in the Connecticut Valley was made by Rev. Thomas Hooker and his band of one hundred journeying over land by foot from Cambridge, still there is no mention made that a physician accompanied them, although Mr. Hooker is supposed to have had, and probably did have, some medical qualifications. The clergy, as was the custom, obtained what medical knowledge they could and bridged the gap in the professional circle, though the pioneers always tried to secure a physician to accompany them to their new homes. Considerable controversy has arisen over a certain John Pratt who was believed to have emigrated from Newtown or Cambridge to Connecticut in 1636 and whom Governor Winthrop termed an experienced surgeon. Names were a repetitious product in those days so we find there were two John Pratts, one a surgeon and one a farmer. It was the farmer who joined Thomas Hooker's colony.

The General Court established in Connecticut granted its first license to practice the art of healing to Thomas Lord. At the age of sixteen he sailed from England with his parents in the *Elizabeth and Ann*, just a year before Hartford was settled. It was not exactly a comfortable voyage in 1635 when Thomas Lord crossed the ocean. Six weeks and three days on the seas was considered a short trip and if one sailed to America via the Barbadoes it took two to three months. The quarters on shipboard were crowded, scurvy and smallpox abounded, and the weakened condition of the hardy souls when they landed served to make them the more susceptible to disease. Suitable

food in sufficient quantities was difficult to secure, the climate was severe, and many were obliged, especially during their first winter in the New World, to live crowded together under unsanitary conditions. But Thomas Lord withstood these rigors and finding his way from the Bay Colony to Connecticut engaged in the practice of medicine and, we are told, was at times employed as a schoolmaster. Of his medical training we know nothing but his schedule of fees as granted by the Court is of interest—a certain sum “if he will remain in town,” the “sum of fifteen pounds for the said ensuing years, and they doe declare that for every visitt or journeye that hee shall take or make, being sent for to any howse in Hartford, twelve pence is reasonable; to any howse in Windsor, five shillings; to any howse in Wethersfield, three shillings; to any howse in Farmington, six shillings; to any howse in Mattabeseck, eight shillings; (hee having promised that hee will require no more;).” The practice of medicine must have been a bit dull for we find that in April 1658 Thomas Lord was chosen schoolmaster in Wethersfield and again in 1659 when a salary of £25 was allowed him with a rent-free house and meadow lot. Chosen schoolmaster again in 1660, he purchased a house from Thomas Williams and there continued till his death, an ardent Royalist.

Four years after the *Elizabeth and Ann* brought Thomas Lord to the New World, the *Defence* brought to Massachusetts Bay a physician, Jasper Gunn, twenty nine years of age. At first he settled in Roxbury but in 1646 he, too, emigrated to Connecticut and established himself at Hartford where he bought lands and was one of the townsmen for the north side in 1655-6. Like Lord he busied himself with something more than pills and powders. Gunn's almanac records that certain goods were sold, and brass kettles were mended; that was in “the service of the mill in 1657”, (probably a saw mill). His accounts show that in addition to owning a shop or store he was a farmer. Subsequently he moved to Milford.

As a result of the visit of the River Sachem Wahginnacut to Plymouth beseeching protection against the dreaded Pequots, Windsor was settled about the same time as Hartford. Its first physician, Bray Rosseter, has immortalized himself by performing the first officially recorded postmortem examination to be carried out in all New England. Rosseter was a well educated gentleman, a product of Massachusetts colony arriving in Windsor among the first settlers. He obtained his license to practice medicine from the General Court and, in addition, enjoyed the honor of being Windsor's first town clerk from 1639 to 1652. Rosseter has been characterized as a dabbler in law suits and a surveyor as well as an ardent physician. Rosseter's fame as a physician, however, seems to have developed more after he moved to Guilford in 1652. Eight years later he was called to Hartford either to attend or to advise in the care of John Talcott, a Magistrate and a very prominent and valuable inhabitant. For this trip Doctor Rosseter was paid five pounds out of the public Treasury on order of the Court. This consultation was appreciated by the neighbors of Mr. Talcott and by the whole colony as well, since the journey from Guilford to Hartford on horseback in March over poor roads was not an easy one. The famous incident of the opening of the Kelly's child for which Doctor Rosseter received twenty

pounds by order of the Court is of considerable interest. Witchcraft was gaining a foothold in Connecticut as well as in Massachusetts. The Connecticut code of 1650 provided that in case of sudden, untimely death a jury of six or twelve discreet men be called by some magistrate or constable to inquire into the cause and manner of death. Elizabeth Kelly, the elder of two children of John Kelly, a man of small estate, living in Hartford, was taken violently ill with something like bronchial pneumonia on the night before Sunday, March 23, 1661-2. In her delirium she cried out against Goody Ayres, a local witch. The ministrations of relatives and neighbors were of no avail and the child died the following Wednesday night. Doctor Rosseter was called from Guilford by the jury, called to inquire into the cause of death. Again a long journey over bad roads. In his report he seems to have been predisposed to attribute the death of Elizabeth Kelly to preternatural causes. The postmortem was made five days after death. Small wonder that some of the appearances described in his report suggest the beginning of decomposition!

At the time Bray Rosseter was Windsor's sole physician and town clerk there was living at Saybrook and later at Pequot one of the most outstanding figures of early Colonial history. Born at Groton Manor, England, in 1606 when his father was but eighteen years old, John Winthrop, Jr., developed into a magistrate, an industrial prospector, a scientist and a physician. He received the best instruction Cambridge and Dublin could afford, travelled extensively through Europe as part of his education, and in 1631 followed his father to this country where his record is one of glowing achievement. Characterized as eager, outgoing, genial, responsive, modern, John Winthrop, Jr., possessed the energy, optimism, and resourcefulness of the American pioneer. For eighteen successive years he was a magistrate of the Bay Colony, then, after a visit to England, he was engaged by Lord Say and Sele and by Lord Brook to establish a settlement near the mouth of the Connecticut River. With his eagerness for industrial possibilities he was attracted to Pequot (now New London). Eight years after the death of his father, he was elected Governor of Connecticut and moved to Hartford. The scientific tastes and attainments of this most popular gentleman are evidenced by the fact that he possessed a library of over one thousand volumes, for a century the best scientific library in the English colonies.

Interested in alchemy and astronomy, John Winthrop, Jr., harbored a natural liking for medicine. The notebook of his medical practice showing the variety of cases treated by him is still preserved. His patients lived for the most part in Connecticut, Massachusetts and Rhode Island. Often they were sent to him but at times he went to them in consultation. Some he even treated by letter without ever seeing them. Winthrop numbered among his patients the most prominent men of the Colonies, together with their families. Thus we find listed, John Mason, Commander-in-Chief of the military forces of Connecticut and for eight years Deputy Governor; Thomas Mayhew, Governor of Martha's Vineyard and Nantucket; Captain John Underhill of Long Island; Roger Williams, founder of Rhode Island; George Hethcote of the Barbadoes; Samuel Gorton of Rhode Island; Edward Wigglesworth, minister, Edward Hopkins and John Haynes, both Governors of Connecti-

cut; William Leete, Governor of New Haven colony and later of Connecticut; and John Davenport, first pastor of New Haven.

Many were the ills for which Winthrop was called upon to prescribe. His first patient was his own father who had injured a finger. A certain Sarah Rood sought his advice for falling out of "ye wome these three years and more after her first child was borne." His remedies included a number of simples dear to ancient women, as elecanipane, elder, wormwood, and anise. Niter he used frequently, giving it in measles, colics, sciatica, headache, giddiness and other ailments. Spermaceti he used for inward bruises. Antimony (probably diaphoretic), a little iron, sulphur or calomel rarely, occasionally rhubarb or jalap, horse-radish, guaiacum, sometimes an anodyne as mithridate, often powder of coral or an electuary of millipedes (sow-bugs)—all these were included in his materia medica. But his best known remedy, Rubila, was one of his own concoction. This remedy was apparently compounded at night when Winthrop was alone and uninterrupted, for Mrs. Davenport of New Haven Colony wrote, "she had rather have been without it than you should get hurt by sitting up too late." The composition of Rubila was handed down to his son Wait and his grandson John, but from then on it was unknown until Oliver Wendell Holmes deciphered a manuscript collection of the medical cases treated by Governor Winthrop from 1657-1669 and came across the following prescription in symbols: Four grains of (diaphoretic) antimony with twenty grains of nitre with a little salt of tin making rubila. Holmes believed that Winthrop may have added something to redden the powder as he constantly speaks of rubifying or viridating his prescriptions. Nauseous though it was in taste and although many objected to it, yet it was kept on hand in many a household, a cure-all for fever, "sweiled legs," colds, colics, agues, and a preventive against fits. One to two grains made up the usual dose, but this was often exceeded. Sometimes one or two teaspoonfuls of molasses were prescribed alone or with a spoonful of "oyle" because of the astringent properties in Rubila. John Winthrop, Jr., served continuously as Governor of Connecticut from 1659 until his death in 1676. He was buried to the sound of the drum, trumpet, and guns from an artillery company in New England's camp santo, King's Chapel burying ground, Boston. As the historian Morison has so fittingly written, "he was the finest flower of New England aristocracy. In him was combined the power to think and the power to do, creative genius and the quality of leadership, the zest of a scientist and the faith of a puritan, a pioneer's energy and the tenderness of a saint."

During this period in New England the offices of clergyman and physician were frequently associated in one individual, termed by Cotton Mather the Angelical Conjunction. These men were generally well educated, of great piety and more than the ordinary industry. Among the distinguished of this group were Gershom Bulkeley of Wethersfield and Isaac Collins of Litchfield. Both of these gentlemen ultimately gave up the ministry. Gershom Bulkeley was a native of Concord, Massachusetts, born in 1636. He graduated from Harvard College at the age of nineteen, became the second minister in Pequot but in 1667 moved to Wethersfield where he was pastor of the church for ten years. It is not known where he obtained his instruction but it is

known that he had a brother Peter who practiced medicine in Fairfield and it is more than likely that both sons gained their medical knowledge from their father, Reverend Peter Bulkeley, an English immigrant to Concord, Massachusetts. Appointed an army surgeon in the war against the Indians he was wounded in the thigh. In 1677 he resigned his pastorate, probably because of a weakness in his voice, and spent the remainder of his life practicing medicine in Glastonbury, having been licensed by the General Court in 1686. Gershom Bulkeley had a large consulting practice all over Connecticut. His reputation was extensive, some patients coming from long distances. His opinion was often requested in difficult cases but records show that it was necessary at times for him to go to court in order to collect his fees. "Nobody of men I venture to assert, loose so large a percentage of their business by the unwillingness of debtors, who know of our reluctance to resort to courts of law, to collect even our very just dues; and I must confess that this reluctance lies in the line of the claim of humanity by our profession, which claim does seem to be somewhat clouded by our resort to the law for relief." After almost three centuries this has a familiar ring!

By the middle of the 17th century exports were beginning to be shipped by sea from Connecticut towns. Simsbury and Windsor produced and exported tar and turpentine and masts were exported for ships to be built in England. As early as 1687 the General Assembly prohibited the exporting of timber and lumber from the colony without a license from the town from which it was taken. In 1645 Farmington was admitted as a town and in 1666 four counties were formed, Hartford, New Haven, New London, and Fairfield. Influenza was epidemic throughout New England in 1647 and twelve years later an epidemic of cynanche trachealis (diphtheria) appeared to run its course for three years. Just prior to Governor Winthrop's ascendancy as a practitioner of medicine the General Court licensed Daniel Porter of Farmington (1654). No record of him remains but he was believed to have been regarded principally as a bonesetter. In 1691 an epidemic visited Hartford County. We read that townsmen of Hartford, Wethersfield, and Windsor were freed from cutting brush on the Town Commons, by reason of sickness. Governor Roger Wolcott six years later reports it a season of great scarcity and mortality. Perhaps this accounts for the large church attendances for on one Lord's Day "great disorder" was reported at the Hartford ferry because of the large crowd going over to church, but it may have been due to the fines levied for not attending public worship, usually 5 s.

With the opening of the 18th century the number of physicians increased. Some of them were well educated and were familiar with the practice of medicine as it existed in Europe at the time. Several had attended lectures of the celebrated men of their time and could read the various works printed in Latin, describing the diseases, and the pathology, and the treatment. To become a respectable practitioner of medicine one had to ride with some medical man for one or two years, then apply to the General Court of the colony for a license to practice Physic and Chirurgery. This application had to be indorsed by a few respectable names. In this way the applicant became a Doctor. Many, however, not wishing to be put to this trouble practiced medicine without any license.

Shortly after the turn of the century, in 1717, Captain John Munson of New Haven was given the sole privilege by the General Assembly for establishing regular communication between Hartford and New Haven, but the roads were so bad travel had to be suspended in winter. It was not until 1772 that we find stage coaches making the journey out of Hartford regularly each week for both Boston and New York.

In these early days we find some outstanding physicians who practiced their profession in Hartford and the surrounding towns. In Windsor were Samuel Mather, Jr., and Alexander Wolcott. Mather was a graduate of Harvard College, licensed by the General Assembly to practice medicine in 1702, a "very respectable" man. Alexander Wolcott, the fourth son of Governor Roger Wolcott, interests us more perhaps because of his negro slave, Primus, than because of his own achievements, although he was indeed a striking character, erect as a palm tree, hair of silvery whiteness hanging down over his shoulders, dark eyes, and dark complexion. Wolcott began practice in Windsor about 1740 after graduating from Yale College and studying in the office of Doctor Norman Morrison. He possessed an extensive library, mostly in Latin, and became one of the most learned physicians of his time. We find him sailing with the expedition to Cape Breton in April 1745, just ten days after his wedding to Mary Richards. The story of his negro slave forms an interesting chapter in early medical history. Primus accompanied the doctor on his rounds and helped compound his medicines. In his old age he was given his liberty as a reward, whereupon he crossed the Connecticut River, set himself up as Doctor Primus and enjoyed a large practice among the white townsfolk of that section of the county, being esteemed a physician of some skill, as he was a man of more than common shrewdness.

In Simsbury a certain Samuel Higley, licensed to practice in 1717, is known as the discoverer of a process for making steel. In 1729 he petitioned the General Assembly for exclusive right to manufacture steel, for ten years. Berlin had its James Hurlburt, born in 1717, a noted character of his time, learned, eccentric, and unfortunate, destined to die in the neighboring town of Wethersfield, penniless, at the venerable age of 77. It was in Doctor Hurlburt's days that Berlin became famous for the manufacture of tinware and from its streets went forth the first traveling tin peddler's carts to find their way into every corner of Connecticut. Granby pointed with pride to its Jewett family, physicians of four successive generations beginning with Nathan Joseph Jewett who obtained his training and fifteen years of experience in Lyme before settling in Granby. Wethersfield had its "bad fish", James Poisson, suspected of "uttering false bills in the county of Hartford." He was found guilty in September 1724 and sentenced to stand an hour and a half in the pillory, and to have the lower part of his right ear cut off, and to endure six months' imprisonment, and pay the costs of his prosecution.

About 1740 the British Government declared war against France. The New England colonies are reported to have entered with spirit into the expedition to Cape Breton and laid siege to Louisburg. Connecticut was well

represented. The siege of Louisburg was proposed by New Hampshire to the respective colonies. Massachusetts refused to listen, thinking the plan bold and hopless. New York and Pennsylvania held back, though the latter advanced £4,000 at a later day to help defray expenses. Connecticut alone became excited over the plan. Most of the planning of the siege and most of the fighting were done by colonial troops and although heretofore physicians had been exempt from military service in the colonies we now find several joining the various expeditions against the French. Both Lieutenant-general William Pepperell and Major-general Roger Wolcott, who commanded the expedition to Cape Breton, were very popular and thus influenced the enlistment of many of the "better sort of people." Connecticut raised four hundred men and sent her sloop *The Defence* with one hundred men for sea service. The reduction of Louisburg was believed necessary for the peace of New England. The Connecticut forces sailed from New London about April 1. The General Assembly ordered April 3 to be kept as a day of fasting and prayer for the success of the expedition. The siege lasted forty nine days and after Louisburg was captured it was garrisoned by New England soldiers, Connecticut sending in July three hundred men to assist in the army of occupation. As second in command it was but natural that Roger Wolcott should desire that his son, Alexander, join him and with this end in view the latter received the appointment of Physician and Surgeon's Mate to the expedition. The appointment of Surgeon went to Norman Morrison, a native of Scotland who had emigrated to the colonies about 1733. He was the first in the Connecticut colony to separate the practice of medicine from that of pharmacy and to encourage the establishment of an independent apothecary in Hartford. Morrison was apparently a thorough and diligent scholar for he possessed a valuable library and inspired his pupils, many of them distinguished, with a taste for reading. Because of his influence as a medical teacher and his superior eminence and judgment as a physician he enjoyed a large consultation practice. As Surgeon of the expedition to Louisburg he was granted a salary of £45 per month but after the capture this was increased to "the sum of fifty-five pounds old tenour per month for the future, during the time he shall be improved in the colony service at Louisburg." On his return home he received a bonus of £65 per month. Doctor Norman Morrison lived in Hartford on Main Street, his garden extending back to Market Street. The house stood three or four rods north of Temple Street but was later moved to Trumbull Street. The original lot as purchased comprised two acres and extended a short distance across the present Market Street. His death came from epidemic pneumonia at the age of fifty five. He was buried in his own garden in Hartford.

Not all were as fortunate as Wolcott and Morrison in their compensation for military service as is witnessed by the following. "Upon the memorial of Doctor John Hart of Hartford, representing that he hath been in quality of physician on board the sloop *Defence*, on the expedition against Cape Breton, and that the fifteen pounds per month heretofore proposed, to be allowed such physician, is, as he conceives, not meet recompense, and praying such addition as to raise it to £25 per month, as per his memorial on file, etc." This request brought to Doctor Hart in October 1745 an increase to twenty

pounds per month.

Physicians accompanied other expeditions sent out from the colonies. In 1755 the General Assembly appointed, among others, to the expedition to Crown Point Doctor Pelatiah Bliss of Suffield and as Surgeon's Mates Elisha Lord of Farmington, Timothy Warner and Gideon Wells of Wethersfield. For the invasion of Canada as Surgeons and Surgeon's Mates there were appointed in 1758 Gideon Wells and in 1759 and again in 1760 Daniel Dwight of Enfield. Doctor Elihu Tudor of East Windsor appears to have been a Surgeon in the expedition against Canada and later with the army which captured Havana. The effect of the climate on his health may have accounted for his visit to England in 1762 where he is said to have continued in the army and enjoyed the benefits of the hospitals there. He was later permitted to retire on half-pay for life by the British government. Seven years after this we find him back in East Windsor where he lived to be ninety three, becoming one of the founders of the Connecticut Medical Society and its second vice president. Like many others of his time Tudor was under suspicion during the Revolution as a Tory but managed to pursue a middle course and maintain his friendship with the British government.

Hartford County had but few physicians known to have participated in the Revolutionary War. Doctor Theodore Wadsworth of Southington, Asaph Coleman of Glastonbury, and John Hart and Timothy Hosmer of Farmington are on record as members of the Continental Army. In 1775 the General Assembly appointed surgeons needed for the army and the Governor filled vacancies in case the appointees were unable or unwilling to accept. A new system was suggested by the physicians of Norwich and adopted. Under this new plan the Assembly chose a Committee of Examiners who passed on those in the state offering themselves as Surgeon's Mates for the Continental Army. Those who qualified were given certificates by this Committee. Of the eighteen members of the Committee but one, Alexander Wolcott, came from Hartford County.

The second half of the 18th century found the towns about Hartford growing rapidly. In 1756 Middletown, then part of Hartford County, led the other towns in population, Windsor being second, Farmington third, and Hartford fourth. Suffield had been noted for some time for its iron works and East Hartford and Suffield both boasted iron slitting plants. Simsbury was mining copper and as early as 1750 was raising and exporting tobacco. Beef, pork and wine were being shipped to the West Indies and bricks were sent to the West Indies and to South America from this section of Connecticut. From 1774 to 1782 we find Farmington leading in population, Hartford second, Middletown third, and Simsbury at first fourth, then third. At this time gunpowder was being manufactured in East Hartford, Canton, Enfield, and Hazardville. East Hartford also boasted the second paper mill to be built in Connecticut and glass was being made in Manchester. After the Revolution East Hartford enjoyed a fourteen year monopoly of the manufacture of snuff and in 1796 the first cotton mill was built in Hartford County at East Hartford, now Manchester. No bridge connected Hartford with East Hartford before the 19th century and we find that until 1758 ferry service across the Connecticut at this point was a haphazard affair. In that

year the town of Hartford voted that two boats be employed in attending the ferry and two years later it voted that one ferryman should live on each side of the river for the greater convenience of passengers.

Several epidemics are recorded during the eighteenth century, notable among these are throat distemper of 1735-1740 so ably pictured by Caulfield. This epidemic first appeared in Hartford County at Farmington in 1736. From there it spread to Simsbury, West Hartford and Hartford. Rev. Colton of West Hartford mentioned the epidemic, probably diphtheria, in his election sermon before the General Assembly of 1737. In 1750-1751 an epidemic of dysentery visited Hartford, having first appeared to the west in Waterbury and Cornwall. This proved fatal to many individuals.

The Connecticut Courant for November 30, 1767 carried an advertisement of an inoculation hospital, evidence of the spread of this method of combatting smallpox. We learn from Chapin's Centennial Discourse delivered in 1853 that inoculation was first voted in Glastonbury in March 1782 and practiced under the direction of "Civil Authority and Selectmen." Two physicians, Elizur Hale and Asaph Coleman, were chosen for this work and these two were permitted to inoculate for smallpox while under bond. Permission for this procedure was withdrawn and reestablished successively until 1790 when it was permitted under direction of "Civil Authority and Selectmen." In 1775 an epidemic of diphtheria again visited New England but Hartford County seems to have been spared the ravages of this disease, Middletown suffering the most severely of any of the Connecticut towns.

Medicine produced several characters of note during the Revolutionary period. Two of these were prominent in Masonry, Doctor John Hart of Farmington and Doctor William Jepson of Hartford. Doctor Hart, graduating from Yale College in 1776, entered the Colonial Army. After the war he settled in Farmington and was then elected Senior Deacon of Frederick Lodge, No. 14, at its organization on September 18, 1787. He later entered the U. S. Navy and died at sea in 1798. Doctor Jepson was educated in Boston as an apothecary and, we are told, was instructed in the art of mystery of physic and surgery. In 1757 he came to Hartford, set up his shop in partnership with Doctor Sylvester Gardner at the sign of the Unicorn and Mortar in Queen (now Main) Street. Doctor Gardner lived in Boston but as the absentee partner furnished the capital for a business including trade in both drugs and groceries as was the custom of that day. When St. Johns Lodge, No. 4, was founded on March 21, 1762 Doctor Jepson is recorded as one of the charter members and later as Senior Warden. Although he was said to have been a skilful physician he petitioned the General Assembly in 1771 for an act of insolvency which was granted the following year.

No doubt many a wife aided her husband in his arduous practice in Colonial days but the records bring to us but one striking example. Doctor Ezekiel Porter practiced in Wethersfield. Little is known of him except that he died before the Revolutionary War and was entirely eclipsed in fame by his able wife Mary. Many are the wonderful stories of her ability as a bonesetter. One of her bills to the Colonial Government is worthy of passing notice. The prisoner of war here recorded is supposed to have been one of Burgoyne's army who broke his leg and was placed under the care of this

skilful woman.

to Mary Porter Dr.

1777	Decr	21	To Travel and setting a broken leg of George Forsyth a Brittish prisoner of war,	£0-5-6
			To 4 Visits dressings and means @ 2/6	
			for Do, ...	10-0
		28th	To 3 Visits dressings and means @ 2/6	
			for Do, ...	7-6
		31	To 3 Visits dressings and means @ 2/6	
			for Do, ...	7-6
1778	Jany	3d	To 3 Visits dressings and means for do,	6-0
		10	To 4 ditto do do for do,	7-0
		15	To 2 ditto do do for do,	5-0
		19	To 2 ditto do do for do,	5
			To 1 phial camphorated spirits for do,	4
		30	To 1 Visit dressing and means for do,	2
	Feby	2d	To 1 ditto do do for do,	2
		5	To 1 dressing in my shop for do,	1-6
	March	5	To 1 do and means for do,	1-6
				£3-4-6

Wethersfield Decembr 31st 1785 Personally appeared, Mrs. Mary Porter and made Solemn Oath that the Articles in the above Acct are justly and truly charg'd said Acct. being Reduced to lawful Silver money.

Coram Saml Wm Williams Just: pece.

In East Hartford, Hockanum district, Doctor Timothy Hall gained reknown as a safe and prudent practitioner. It is said of him that time troubled him but little, and he was disposed to talk, chiefly about profes- sional matters, making inquiries about disease, new remedies, and the like, and did not fail to relate his experience. After the beginning of the 19th century Doctor Hall became active in the Connecticut Medical Society as treasurer in 1808-1812 and as vice president in 1813 and 1814. For many years he was a justice of the peace. He is perhaps best known for his paper on Petechial or Spotted Fever, published in 1810.

In that part of East Hartford now known as Manchester Doctor George Griswold practiced. According to the custom of that day he studied medicine under another practitioner, a Doctor Abernethy of Litchfield County, about 1784. Griswold was also a charter member of the State Medical Society and in 1800 a member of the General Assembly.

The lower part of Wethersfield known as Stepney Parish, now Rocky Hill, numbered eight hundred to nine hundred souls prior to 1774 but had no physician, depending on Wethersfield in times of sickness. In 1774 Doctor Aaron Horsford came over from Marlborough and practiced there till his death in 1804. His reputation is two fold, for commercial ventures in which he engaged with the junior Captain Oliver Goodrich and for his successful treatment of colic, a comprehensive term then used to include all pains and irritations in the abdominal region. Doctor Horsford compounded a physic

pill which was greatly in demand. The formula was kept by his granddaughter and these pills were still sold seventy five years after his death.

Hartford was well supplied with physicians during these Colonial days. Shortly before William Jepson set up his apothecary shop on Queen Street, Thomas Langrell, a native from Lebanon and a graduate of Harvard College, settled in Hartford. He was destined to meet an untimely death. Bent on crossing the Connecticut River one June afternoon in 1757 on a quest for rose leaves, Langrell was drowned in an attempt to rescue his companion, William Harpy, who had fallen out of their small boat. The inscription on his tombstone is characteristic of the sentiment so often expressed in those days:

"Drowned in the glory of his years,
And left his mate to drown herself in tears."

Doctor Joshua Hempsted who was a bonesetter left a memorandum with charges for services which should interest orthopedists today.

"Capt. Samuel Wadsworth to Joshua Hempsted—Dr.

March 9th,	1783, to Reducing Fractured Leg for Negro	
	Child, Dressing & plasters,	£0: 2 : 6
	to three Dressings & plasters,	0: 3 : 0
May 12th,	to Reducing Fractured Ribs for Negro man &	
	Dressing & plasters	0: 2 : 6
	to three Dressings & plasters,	0: 3 : 0
		£0:11: 0

as this Small acct is of Sum years Standing the Ballance will be acceptable to yr Humble Servant.

"On the 26th of August, 1790, Recd the within Sum of Eleven Shillings which (is) in full of all accounts to this Day pr me Joshua Hempsted."

The three best known physicians in Hartford in the latter half of the eighteenth century were Doctors Lemuel Hopkins, Mason F. Cogswell, and Eli Todd. The latter two belong more to the early 19th century but Lemuel Hopkins is distinctly an 18th century figure. Characterized as a preceptor who possessed genius and learning, Hopkins combined the rare skill of a physician with the unusual poetic wit of a humorist and satirist. He was born in Waterbury in 1750, studied with Doctor Jared Potter and Doctor Seth Bird, and began the practice of medicine in Litchfield about 1776. Moving to Hartford eight years later, he took up his abode on the west side of Main Street a short distance south of Christ Church. His tall, lean, stooping figure with large features, eccentric and uncouth, was to be seen daily on the streets of Hartford. The year he moved to this locality Yale bestowed on him an M.A. degree, evidence perhaps of his growing indefatigability in literary and scientific labors. His fame increased until it is no exaggeration to say that he enjoyed the highest reputation of any physician in the state. He used the lancet, and antimony, and calomel and opium with a liberal hand. Equally famous as a member of the Hartford Wits, Doctor Hopkins is known for his many squibs and verses which he wrote but which never were published in collected form. The bludgeon satirist, an eponym

applied by Goodrich, perhaps best describes him. "Epitaph on a Patient killed by a Cancer Quack," "The Yellow Fever in New York in 1798," contributions to "Anarchiad," and "Political Green-House" are among his best known writings. He was a contributor to the "Echo," serial satires in verse by Hartford wits containing many allusions to Connecticut traditions, as Captain Kidd, the Blue Laws, the Windham Frogs, the Hebron Pump, etc. The description of Doctor Hopkins' death by his brother-in-law, Doctor Sheldon, is almost a classic. "His legs swell'd to his knees with an entirely inelastic feel, great oppression of breathing, prostration of strength, & much altered countenance, & he has from thence gradually continued to decline." In his honor the Hopkins Medical Association was formed in Hartford on June 14, 1826.

The method of medical instruction in these early days was entirely by precept and example, there being no medical school available in New England. The prospective doctor was taken about the town, visiting patients in company with some physician of experience, sharing in his long calls and listening to his oft-repeated stories and jokes. This bedside teaching was invaluable. It at once combined what then existed of the science of medicine with the art of medicine. The doctor filled his own prescriptions before the first apothecaries appeared, often designating them as my pill, my syrup, etc. No regular office hours, he traveled on horseback from early morning till late evening, eating wherever he happened to be, always the recipient of hospitality, perhaps sometimes too much, and engendering a bond of friendship between his patient and himself which was passed on to the next generation. "The entering into a household, the conduct therein, and the rare knowledge of leaving when nothing more is to be said or done, is an art to be learned nowhere else but in a household, and among the folk therein gathered. The fortune of many a brilliant man has been marred by his ignorance of a pleasant entrance, and by his want of a peaceful departure. It is the gilded pill and the pleasant draught which tickles the palates of the multitude; and the gracious manner, which leaves a kind remembrance behind." Of such was our early Hartford County physician.

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DIET AND BRIGHT'S DISEASE

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BEFORE ENTERING upon the discussion of "Diet and Bright's Disease", it seems essential to define the use of the term "nephritis." Although "nephritis" is used to describe a primary bilateral disease of the kidneys of a more or less specific nature, characterized by diffuse inflammatory tissue reactions; frequently "nephritis" and "Bright's disease" are applied interchangeably to a group of renal diseases related to one another in several characteristics. It is in this latter sense that nephritis will be used in this discussion.

Bright, in his original paper over a hundred years ago, described a disease of varied etiology leading to renal failure. In the century following this great contribution, important advances have been made in the classification of diseases of the kidney. Many of these classifications have emphasized the differential characteristics without adequate attention to the common features in the natural history, morbid anatomy, and physiology. At times kidney diseases have been arbitrarily divided into "medical" and "surgical" types, and so important a cause of hypertension and renal insufficiency as pyelonephritis has not been considered as a form of Bright's disease. It is only in recent years that a better balanced knowledge has begun to emerge.

Infections, exogenous, and endogenous substances as well as the aging processes affect various portions of the nephrons and the renal vascular tree. Separation of kidney disease into various types according to the specific localization of the functional or structural damage is justified. As the renal disease progresses, however, the specificity of clinical, physiologic, and structural differences usually becomes less, because gradually many or all parts of

the nephrons and blood vessels become affected. Thus cases in which the clinical picture includes hypertension, hyposthenuria, and albuminuria, and which at postmortem show small kidneys with vascular sclerosis, disintegration of the glomerular structures, and dilatation of tubules, are far more common than cases with a more specific and restricted type of pathology. The collective term Bright's disease is, therefore, still useful to remind physicians that these groups of renal diseases are interrelated.

In the therapeutic management of patients with Bright's disease the situation is not unlike that involved in the treatment of diseases of the heart which lead to congestive failure of the circulation. Just as specific treatment is required for rheumatic and for syphilitic heart disease, while the congestive failure caused by these diseases is managed in essentially the same manner; so in the therapeutic approach to kidney diseases, in addition to the specific considerations, there are a number of measures applicable to several or all types, particularly in the advanced stages.

Among anatomic and functional considerations the following bear on the rationale of dietary treatment of Bright's disease. There are approximately one million nephrons in each kidney. The normal function of the kidney depends on proper function of these units, although adequate performance can be maintained by one half or one third of the normal number of glomeruli. The urinary filtration takes place within the glomeruli. The capillary pressure within the glomeruli is unusually high, and it is this force which causes the outward transudation of water and electrolytes. The colloidal pressure created mainly by the blood proteins tends to counteract the filtering capillary blood pressure. Hence for the formation of urinary filtrates it is essential that the capillary pressure be higher than the osmotic pressure. Similarly the hydrostatic pressure within the Bowman capsule will counteract the efficacy of the filtering capillary pressure. Abnormally high pressure within the Bowman capsule may be due to pathologic obstruction of urinary passages or to

impaired tubular reabsorption with resultant "backing up" of the filtrates.

The surface of the normal glomerular semipermeable membrane in man has been estimated as 1.5 to 2 sq. meters, equalling in size the surface of the human skin. It has been estimated that 1.3 liters or about one third of the normal blood flow runs through the kidney every minute in order to accomplish the filtration process. In most cases of Bright's disease there is not only a change in the permeability, but usually, too, a progressive reduction of this filtering surface. The gradual disintegration and disappearance of the glomeruli can be caused by primary glomerular lesions, by obliterative lesions of the afferent arterioles, or by affection of the tubules as in the case in pyelonephritis.

It is essential to keep in mind the fact that only a small fraction of the filtrate volume is eliminated as urine. Thus out of 100 cc. of filtrate formed in the glomerulus approximately 99 cc. are reabsorbed in the tubules of the normal kidney. If tubular reabsorption is impaired due to selective disturbance of reabsorptive capacity, to reduced tubular surface, or to an abnormal increase in rate of filtration within the individual glomeruli, there is a tendency to polyuria and hyposthenuria. The importance of tubular reabsorption will be well appreciated if we recall that in the total urinary filtrate formed in 24 hours about two pounds of salt and a half pound of glucose and bicarbonate is eliminated from the blood, but that the bulk of these vital substances re-enters the body by means of tubular reabsorption.

Under normal conditions the glomerular capillaries are impermeable to plasma proteins and certain other substances which the body cannot spare. In disease or under physiologic stress, such as severe muscular exertion or exposure to cold, this permeability is altered. If the capillary permeability increases, proteinuria develops. In Bright's disease, proliferation of glomerular cells or thickening of the basement membranes frequently causes decreased permeability with the result that waste products accumulate in the blood. Usually, however, such insufficient filtration and consequent chemical retention in the blood results from reduced glomerular surface caused by progressive disintegration and disappearance of the functioning nephrons. Thus a comparison of the number of glomeruli in normal subjects with that in chronic renal insufficiency caused by chronic glomerulonephritis or nephrosclerosis indicates that they may be reduced from 1

million to 500,000 or less in one kidney. Correspondingly the filtering surface of the glomeruli is reduced from 1.5 sq. meters to about 0.7 sq. meters or less. As judged from histologic appearance, a large portion of the glomerular surface which remains is diseased, and the permeability of various parts of this surface is not uniform, but varies depending on the ischemic inflammation and other factors. Thus within certain areas permeability is increased; in others it remains normal; and in still others it is decreased. It is this combination of factors which results in the paradoxical situation where on the one hand there is retention in the blood of such small molecular substances as urea, creatinine, and uric acid, and yet on the other such large molecules as those of albumin appear in the urine. Retention of urinary waste products in the blood is the result of inadequate filtering surface and impaired permeability within some portion of this surface; while the proteinuria is caused by increased permeability over other scattered portions of the same surface.

Because Bence-Jones protein has a molecular weight considerably less than that of albumin, the former escapes through only slightly altered glomerular capillaries. The molecule of albumin is smaller than that of globulin, and hence with progressive injury to the glomerular capillaries, the appearance of albumin in the urine precedes that of globulin. Hypoproteinemia in Bright's disease, however, is not the result of protein loss alone. Some evidence suggests that at least in advanced stages of nephrosis and glomerulonephritis there is also an impairment of protein formation.

Because albumin escapes from the blood into the urine before globulin does, inversion of the albumin globulin ratio of the blood is common in Bright's disease. The low osmotic pressure of the blood in certain types and stages of Bright's disease is one of the factors responsible for the formation of edema. In the early stage of glomerulonephritis, interstitial nephritis, pyelonephritis and glomerulonephrosis of toxemia of pregnancy, a slight degree of diffuse, hard edema ("nephritic edema"), frequently associated with headache and other cerebral symptoms, occurs even without hypoproteinemia. The mechanism of this edema I do not understand. The usual explanation that the capillary permeability is increased throughout the body and the escaping plasma protein binds the water, is not borne out by facts. It is more probable that there is a selective retention of sodium in the tissues caused by unknown factors.

One of the fundamental functions of the kidneys is the maintenance of the delicate acid-base equilibrium of the blood. Excretion of acids requires simultaneous elimination of the base. In addition to the fixed base of the plasma, sodium salts and ammonia are used chiefly as bases for elimination of acids. The formation of ammonia within the normal kidneys for the purpose of acid excretion is greatly impaired in renal insufficiency, and hence tendency to acidosis in this condition is great.

It is obvious, then, that in the understanding and treatment of Bright's disease, it is essential to consider simultaneously the structural, physiologic and chemical deviations from the norm. In therapy, the management of certain features is the same in different types of renal disease, but specific consideration of the individual disease and its manifestation in the particular patient is essential.

The dietary treatment of patients with Bright's disease has always been the center of the therapeutic approach. Unfortunately, however, in the past many of the dietary regimes practiced have been without rational basis. This resulted in much fad, confusion, and often injury to the patient. We shall approach this problem from the rationale of diets in various syndromes associated with Bright's disease.

Early Stages of Acute Glomerulonephritis and Interstitial Nephritis with Oliguria:

In acute diffuse glomerulonephritis and in acute interstitial nephritis, as well as in cortical necrosis of the kidney, oliguria is a common feature, for which the causative factors are both intrarenal and extrarenal. Thus in addition to the acute obstructive glomerular factors interfering with the local formation of the urinary filtrate (glomerulonephritis and cortical necrosis) or with the flow of that filtrate due to tubular obstruction (interstitial nephritis); extracellular factors such as low blood sodium and hypoproteinemia are also responsible. During the formation of edema, fluid and sodium chloride escape into the tissues and fail to reach the kidneys. This sodium retention in the tissues is influenced by several factors, of which low osmotic pressure of the blood caused by hypoproteinemia is one of the important ones. The dietary treatment in this stage depends on the relative rôles of these intrarenal and extrarenal factors. Certainly to place routinely patients with oliguria due to glomerulonephritis or interstitial nephritis on a Karel diet containing only 800 cc. of fluid daily is not good practice.

The dietary management of patients during the

early stage of acute glomerulonephritis, interstitial nephritis, or glomerulonephrosis of toxemia of pregnancy associated with oliguria, requires individual consideration. Whenever feasible, these patients should be admitted to a hospital, because usually proper therapeutic supervision cannot be conducted at home. The amount of fluid and salt to be administered to these patients depends on the water, sodium chloride, protein, and nitrogen content of the plasma, on the volume of the urine, and on the change in the patient's weight. Hence it is essential to have measurements of these factors taken frequently, often daily.

Volhard advocated the prohibition of food and drink with the exception of 2 cups of weak tea per diem for 3 to 5 days. This measure is supposed to give the kidneys a "rest" and to enhance diuresis. I am not convinced of the efficacy of this measure. One may place the patient for 3 to 5 days on a Karel milk diet, adding fruit juice and lactose to raise the number of calories. Subsequently, however, the total intake of fluid per diem in these patients should seldom be less than 1500 cc. This amount, corresponding to the average loss of water through the skin and lungs, should be maintained even in the presence of edema and normal chloride content of the plasma, except for 7 to 10 days. If the presence of severe edema or nervous symptoms necessitates a more prolonged restriction of fluids, the total daily intake should be estimated by giving 1500 cc. plus the volume of the oliguric urine. If the oliguric urine has a low specific gravity and there is nitrogen retention, the fluid intake should not be restricted below 2000 cc., because of the danger of uremia. One should recall that since water is retained in the body as salt solution, even a fairly large amount of water will aggravate the edema less if sodium salts are not available. With a chloride concentration of the plasma above 95 milliequivalent, therefore, the diet in this acute stage should contain a minimal amount of sodium chloride up to 2.5 gm. With a lower concentration a temporary increase in the administration of salts is indicated. In the presence of hard edema ("nephritic edema") associated with normal or with only slightly reduced protein content of the plasma, an excess of sodium salts in particular is prone to precipitate cerebral symptoms. In the presence of soft edema ("nephrotic edema") sodium salts are less likely to cause symptoms or other harmful effects.

There is no clinical evidence indicating that pro-

tein harms either the normal or the diseased kidney. Thus the evidence available indicates that in patients with scarlet fever or other infectious diseases, the incidence of Bright's disease is the same in those kept on an ordinary diet containing an abundant amount of meat, as in those fed on the old-fashioned milk diet or low protein diet. Indeed, the general condition of the patient is better on a normal balanced diet than on a milk diet. Further, a free milk diet (3-4 l. per diem) is a 90-120 gm. protein diet, containing 5-7 gm. of sodium chloride. Naerra administered a liberal protein diet to a group of patients with nephritis. On this regime the arterial pressure did not become accentuated; there was no increase in the elements of the urinary sediment; and the edema in these cases subsided. There was, however, some increase in albuminuria. During the initial oliguric stage of nephritis, restriction of protein is, nevertheless, advisable for 2 to 3 weeks, for so short a period will not exert a harmful effect on nutrition. At this stage the calories are supplied mainly in the form of carbohydrates, honey, candy, corn starch, rice, cooked vegetables, cooked fruits, lactose, and citrus fruit juices (lemonade, orange juice etc.). Such a carbohydrate diet, containing 1500 to 2000 calories, and reinforced with vitamin concentrates, will decrease the intrinsic protein metabolism of the body. Excess administration of vitamins is not indicated, because there is no valid evidence indicating that they prevent or influence the course of acute Bright's disease.

With the subsequent improvement of the renal function and nitrogen retention and with the subsidence of oliguria, the fluid intake is raised gradually, and the diet should now contain 30 to 60 gm. of protein. The rest of the food should be chiefly carbohydrates with some fat. It is immaterial whether the proteins are supplied in the form of white or red meat. In fact animal or vegetable proteins are eliminated with equal ease. In the selection of the source of proteins the only consideration is their digestibility. Salt restriction (less than 2 gm. of sodium chloride) should be continued. Such a low sodium diet is attained by not adding salt in cooking the food, by boiling the meat, and by prolonging the boiling of vegetables. Meat soups should be avoided. Salt poor diets are monotonous, and selection of an appetizing variety of food is, therefore, particularly important. The use of lemon, lime, and certain vegetable and root extracts will improve the taste of the food. Addition of organic sodium salt to the diet is contraindicated. An acid-ash diet

with low sodium will be helpful. The validity of the claim that addition of potassium salts to the diet is specifically helpful in the treatment of edema is questionable. However, if the low sodium chloride diet is not palliative, addition of potassium salts such as potassium chloride or potassium nitrate may be used as a salt substitute. Two to 5 gm. of these salts may be added to the food. As glomerulonephritis reaches the more chronic stage, the protein content of the diet should be 10 to 15 per cent of the total calories, that is 80 to 120 gm. High protein diet, i. e. more than 120 gm. per diem, is not indicated.

In patients with focal (hemorrhagic) glomerulonephritis, often associated with gross hematuria which sometimes accompanies pneumonia and other infectious diseases, symptoms and edema are usually absent, and special diet is not indicated. In patients with oliguria due to renal damage caused by transfusion reaction, it is essential to maintain an alkaline urine.

The Nephrotic Syndrome:

This syndrome usually develops during the sub-acute or early chronic stage of glomerulonephritis. Frequently it is the first manifestation of a long persisting and undetected proteinuria, like that associated with amyloid degeneration, glomerulosclerosis, and glomerulonephrosis. Such silent proteinuria is frequently the forerunner of other urinary manifestations of glomerulonephritis. For this reason the majority of cases of "nephrosis" are subsequently relabelled as "glomerulonephritis." Instances of uncomplicated "lipoid" nephrosis are rare, and the features of the disease probably depend on alterations in the physicochemical properties of the glomeruli.

The edema of the nephrotic syndrome is soft, diffuse and massive, but partially dependent on gravity. This edema is caused primarily by the lowered osmotic pressure of the blood, the hypoproteinemia in turn originating from the severe or long-continued proteinuria. The problem as to whether the synthesis of protein is normal or impaired in patients with the nephrotic syndrome is still unanswered. It appears that for some time after the development of the nephrotic syndrome the protein synthesis remains unimpaired (Kentmann and Bassett), but in other probably chronic cases protein formation may become disturbed (Leutschner). The latter concept is in harmony with clinical evidence that a high protein diet is frequently *not* successful in raising the protein content

of the plasma. In spite of this, high-protein and sodium-poor diet with 2000 cc. of fluids should be tested for weeks on every patient with subacute or chronic nephrotic syndrome. At no time, however, must limitation of salt and fluids interfere with the consumption of food, particularly proteins.

Pyelonephritis:

In acute pyelonephritis caused by *B. coli* infections ketogenic diets have been used in the past. Since, however, it has been shown that formation of certain organic acids is the effective agent in such a diet, ketogenic diets are no longer used, because it has been found that a combination of acid producing salts and mandelic acid is more effective and better tolerated by the patients. In case sulfanilamide is the therapeutic agent of choice, the volume of fluid administered should be regulated, so that the volume of urine does not exceed 500-700 cc. per diem. Sulfanilamide is usually ineffective when the renal function is impaired. If pyelonephritis is accompanied by renal failure or uremia the dietary regimes are the same as in other types of chronic Bright's disease.

Chronic Bright's Disease Without Edema:

Patients with chronic Bright's disease present many common features regardless of the nature of the initial renal disease [i. e. glomerulonephritis, nephrosclerosis, pyelonephritis, glomerulonephrosis of toxemia of pregnancy, interstitial nephritis (tubular nephritis), glomerulosclerosis or congenital hypoplasia]. In the chronic stage of each of these diseases, we are dealing with a scarred kidney reduced in size. The number of nephrons present are greatly reduced and many of the remaining ones are injured. Likewise the arterial vessels, especially the afferent arterioles, are diseased, and their lumens narrowed. As a result, in all these diseases the kidney reserve is impaired as the hyposthenuria indicates; hypertension is present; and edema is usually absent, or if present is usually nephrotic or cardiac in origin.

Because this stage of the disease usually lasts many years, while the kidneys are functioning adequately, the dietary measures should be aimed at building up or maintaining optimal nutrition. If the patient is overweight this should be remedied. The protein content of the diet should be 80 to 120 gm., for prolonged protein restriction is harmful, and results in bodily and cardiac weakness, anemia and other untoward reactions. Because of the popular belief that meat in any form is harmful in Bright's disease,

it requires tact and patience to persuade many patients to consume such a diet. If edema is not present salt restriction should not be practiced, but if it is present, its nature should be investigated and it should be treated accordingly. Thus if hypoproteinemia exists, the protein level of the blood should be raised by a protein diet or by other means. In the absence of edema the water intake should not be restricted but patients should be warned against the popular habit of drinking an excess amount of water. Alcohol, tea, and coffee in moderation are permissible.

Arterial Hypertension:

The hypertension associated with edema such as that occurring in acute glomerulonephritis, interstitial nephritis and glomerulonephrosis of toxemia of pregnancy should be differentiated from the hypertension of chronic Bright's disease without edema. In the former type dietary measures are efficacious; in the latter diet plays little or no rôle.

In acute Bright's disease the hypertension is usually associated with cerebral symptoms and with hard (nephritic) edema. Sodium restriction improves the symptoms and the edema, and reduces this type of hypertension; while conversely free administration of sodium chloride or of soda accentuates the hypertension and aggravates the symptoms. Indeed convulsions, which are often serious or fatal, can result from indiscriminate use of sodium salts in the presence of this type of hypertension. Even if some urinary retention is present, these seizures do not represent true uremia, but they do represent special types of encephalopathy. A low sodium diet given to such patients should contain 1500 calories, 1500 to 2000 cc. of fluids, 40 to 60 gm. of protein, 160 gm. of carbohydrate and 80 gm. of fat.

Low sodium diet, on the other hand, exerts no beneficial effect in the hypertension of *chronic* Bright's disease regardless of whether that hypertension is caused by nephrosclerosis, glomerulonephritis or pyelonephritis. The prolonged use of low sodium or "salt free" diet, which is still practiced by some physicians, is not indicated and is not practical for any length of time, for often it weakens the patient. That there is no evident simple correlation between the usual types of chronic hypertension and sodium chloride intake is further demonstrated by the fact that hypertensive patients who use salts excessively do not develop an increase in blood pressure or accentuation of symptoms.

Rigid diets in patients with hypertension are still in vogue, particularly in Europe. In Germany periodic fasting of from 5 to 10 days duration, followed by a gradual return to a low sodium diet, has been advocated recently. Studies and clinical experience fail, however, to confirm the claim that under-nutrition with calorigenic food stuffs is more than symptomatically beneficial in chronic hypertension without renal failure. It is not what, but how much the patient eats that is important in uncomplicated hypertension. Kampmann of Germany stated recently that the combination of rigid salt free diet with periodic fasting of about 8 days duration has yielded better therapeutic results than any of the numerous other methods of treatment used in the Volhard Clinic. On this regime during fasting usually about 750 cc. of fruit juices or tomato juice are given daily. One cup of tea or small amount of fresh fruit or salad may be added. No other fluids are allowed. In addition the initiation of such a diet is preceded by a saline laxative. The patient is usually not kept in bed, and walking exercise is allowed. Following the strict fasting period the patient generally, in 3 days, returns to the salt free diet. During this transition period potato, vegetables, salads and applesauce are added to the diet. Depression, nervousness, and weakness have developed in some of the fasting patients. It is advocated that the diet be strictly supervised in old persons. In presence of severe heart failure and particularly in myocardial infarction the diet is contraindicated. The fact that there has developed in some patients increased tendency to collapse indicates that this dietary restriction is severe enough to disturb considerably vital bodily functions. There must be also considerable dehydration during fasting. I have had no experience with this drastic therapeutic procedure.

Renal Failure and Uremia of Chronic Bright's Disease:

In progressive renal failure there are several features bearing on dietary treatment. As the kidney loses its capacity to concentrate the filtrate, more water must be excreted to facilitate the discharge of electrolytes. Subsequently inorganic acids, phosphates and sulfates in particular accumulate in the body. Chlorides, on the other hand, continue to be swept out with the diluted urine. Sodium is used increasingly as a base in the elimination of acids; in the presence of the impaired ammonia formation, a

characteristic of the chronically damaged kidney; the first reserve of fixed base is the sodium of the blood plasma and interstitial fluids. The sodium depletion is frequently accelerated also by vomiting or diarrhea. All these factors enhance the tendency to acidosis and dehydration. With the lowering of reserves of fluids and sodium in the tissues, the plasma volume decreases and the impaired renal flow hastens complete disintegration. Simultaneously the blood calcium becomes low due to hypoproteinemia and the retention of phosphates. Anemia of nutritional origin can be present at any stage of Bright's disease, but with chronic renal failure a special type of anemia develops which is often severe. Many characteristics of this anemia suggest that it is the result of depressed bone marrow function.

Treatment of chronic renal failure, including dietary measures, is in many respects the opposite of that practiced in the acute stage of nephritis with edema. As edema is usually absent when nitrogenous products accumulate, water can be administered freely, but a volume over 2500 or 3000 cc. is seldom indicated. Depending on the stage or the rate of renal failure, moderate (40 to 80 gm.) or severe protein restriction should be instituted. As a rule the diet should contain 7 to 10 gm. of sodium chloride to compensate for the loss in the urine. Whenever a base is needed, addition of organic salts of sodium such as malate, citrate or tartrate is particularly useful. On the other hand when salt is to be restricted, there is no virtue in giving these organic sodium salts. The adequacy of the administration of the sodium chloride can be gauged by the sodium chloride content of the plasma, which should be kept between 96 to 102 milliequivalent. If acidosis is present the addition of a small amount of sodium bicarbonate (2 to 3 gm.) may be tested. Vegetables and fruit juices yield relatively high amounts of base as well as of potassium. It should be remembered, however that the very loss of renal regulatory function on the acid-base balance results in easy precipitation of alkalosis.

The anemia of nephritis responds to diet only if it is caused by dietary deficiency or by blood loss. The anemia of chronic Bright's disease, on the other hand, is refractive to dietary or to any other therapeutic measure.

In the presence of uremia, caused by chronically insufficient kidneys, diet therapy plays only a small

(Concluded on page 527)

GASTRO-INTESTINAL SYMPTOMS IN EYE, EAR, NOSE AND THROAT DISORDERS

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DISORDERS IN the eye, ear, nose and throat producing gastro-intestinal symptoms are frequent. The gastro-intestinal symptoms may be the only manifestations of such lesions. Pathology in the gastro-intestinal tract in some instances is the result of eye, ear, nose and throat pathology.

Last year, I¹ reported a case of perforated peptic ulcer from an abscess of the brain of otitic origin. This was the story of a twenty-six year old female upon whom a radical mastoidectomy with exploration of the dura was done in view of the preoperative diagnosis of chronic left suppurative mastoiditis with cholesteatoma and possible extradural or intradural abscess. At operation a suppurative mastoiditis and a cholesteatoma were found, but not an extradural abscess. The brain was not explored. The immediate post-operative course was uneventful but eventually changed into one suggesting the presence of a lateral sinus thrombophlebitis and possibly a brain abscess. A second operation was planned, but the plan was aborted by the sudden death of the patient four hours before the scheduled operation. Post-mortem examination revealed a brain abscess involving the left occipital and temporal lobes, and, to our intense surprise, a large, acute perforated ulcer on the lesser curvature, posterior surface, distal third of the stomach. The surprise was prompted by the lack of gastro-intestinal symptoms or signs prior to death. On the basis of the reports of Cushing² and others we felt that the perforated ulcer was neurogenic in origin, the sequel of the brain abscess. The mechanism of such ulcer production is probably a parasympathetic-sympathetic imbalance, either through stimulation of a parasympathetic center in the interbrain, or through paralysis of the sympathetic center from effects of lesions of the brain.

While in the above case the gastro-intestinal lesion was silent and the etiological factor suspected, the

process is more often reversed: the gastro-intestinal tract gives symptoms which reflect an obscure cause. A chronic mastoiditis with cholesteatoma can produce gastro-intestinal upsets without signaling its presence. The "silent mastoid" of the pneumococcus type III, with or without a running ear, is a notorious offender, and dangerous. In an obscure gastro-intestinal case, a history of a relatively recent otitis media which clinically appears to have healed should place one on guard.

Latent mastoiditis, so called because of absence of ear symptoms and findings, linked with cases of atypical dysentery producing malnutrition, diarrhea, vomiting, acidosis, dehydration, weight loss, fever and severe prostration was propounded as a disease entity by Mariott³ and others^{4,5,6,7,8,9}, about fifteen years ago. They believed that about 75% of the water diarrheas occurring in cooler months are to be attributed to infections in the ear and mastoid. Their contentions are based upon: a) the clinical improvement that is occasionally obtained upon opening the middle ear and mastoid; b) the finding of pus in the middle ears in from 60% to 70% of autopsies on infants dead of diarrhea; c) the middle ear anatomy of the infant, which is unfavorable for antral drainage due to the presence of embryonic mucosa, particularly in the attic and mastoid antrum. Many later writers,^{10,11,12,13,14,15,16} on the basis of their investigations, oppose the views of those above-mentioned. They contend that: a) in the usual fatal illnesses of infants, ear infection is a terminal event; b) enteritis, as shown by autopsy, too frequently antedates the ear infection for one to assume that the latter is primary; c) serious otologic infections may be present in infants without grave nutritional disturbances. Regardless of the view which one holds, the association of the aforementioned gastro-intestinal symptoms with obscure otogenic sepsis in an occasional case can not be denied and must be borne in mind.

The nausea and vomiting that is associated with severe vertigo, tinnitus, nystagmus and deafness, known as Ménière's symptom complex is now uni-

versally recognized, and the victim is often referred to the aurist for a search for causes in the ear, a quest which is at times successful, more often not. Theories of etiology and modes of treatment have been many and none has been completely satisfactory. Sheldon and Horton¹⁷ of the Mayo Clinic have just reported the successful treatment with histamine of fifteen patients suffering with Ménière's syndrome. They believe that the site of lesion is in the inner ear itself and the most likely responsible factor is local alteration in the permeability of the capillary wall with secondary local edema. Histamine is an important agent which affects capillary permeability. A dose of 1.9 mg. of histamine acid phosphate dissolved in 250 cc. of normal physiological salt solution was administered intravenously, slowly, in about one and a half hours. In some instances the same amount of histamine was administered on either two or three successive days. All patients responded in a spectacular manner. This contribution appears to be a notable advance in the management of this disabling affliction.

Of the causes of Ménière's syndrome not generally recognized, are infections of the sphenoidal and posterior ethmoidal sinuses. It is difficult to find mention of this in the literature. I had two cases of my own which I thought were due to sphenoidal infection but hesitated to accept this idea because of the paucity of reports of parallel cases. Recently, Doctor T. S. Love¹⁸ reported the association of Ménière's syndrome with posterior sinus disease and mentioned his experience in 52 cases. Love uses a simple and successful method of treatment, namely, displacement irrigations of the sinuses, in the method of Proetz, using a solution of 1% ephedrine or ¼% neosynephrin in normal saline. The displacement irrigations reproduced vertigo and nystagmus, the intensity of which lessened as daily treatments progressed. Usually, by the sixth day all symptoms subsided.

To mention infections of the sinuses and oropharynx as foci producing gastro-intestinal disease as gastric and duodenal ulcers, gastritis, colitis, cholecystitis and appendicitis is treading on a ground of combat, with the pendulum of thought on the importance of focal infection swinging in a reverse direction. Regardless of the trend, one can't help being impressed by such as Pickworth's¹⁹ report of a case of chronic sphenoidal sinusitis in which diplococci were found invading the mucosa *from the surface*, spreading to the periosteum, and



FIGURES 1 AND 2

The usual x-ray plates showing the anterior-posterior views of the maxillary and ethmoidal sinuses. No pathology is discerned in these plates.

penetrating the Haversian canals in the bony wall of the sphenoid to enter the capsule of the pituitary gland and the gland itself. Similar diplococci were also demonstrated in the deeper layers of the hemorrhagic patches in the gastric mucosa, a blood-borne metastasis.

The sinuses are often discounted as a source of infection because of the failure of the usual methods of examination, including x-ray pictures, to locate such foci. With the advent of laminagraphic x-ray



FIGURE 3

Laminagraphic x-rays of the sinuses. The slide marked 5 (5 centimeters) is approximately through the mid-point of the ethmoid labyrinth. The slide marked 6 (6 centimeters) shows the posterior ethmoids and the slide marked 7 (7 centimeters) shows the sphenoids. In these three views there is definite cloudiness of the left side as compared with

the right.

This method was developed at the Edward Mallinckrodt Institute of Radiology. These pictures were made from lantern slides furnished by Doctor Sherwood Moore of the Edward Mallinckrodt Institute of Radiology, Washington University, and Doctor A. J. Cone, of the Oscar Institute, Washington University, St. Louis, Missouri.

plates, we undoubtedly shall be able to more thoroughly investigate the more elusive posterior sinus group. Figures (1), (2), and (3) are x-ray pictures of the sinuses of the same patient. Figures (1) and (2) were taken with the usual technique and show no definite pathology. Figure (3) shows laminagraphic pictures and distinctly reveals pathology in the left posterior ethmoid and left sphenoid sinuses.

The recurrence of gastric ulcers following the onset of acute upper respiratory infections is a fact accepted by most gastro-enterologists. There are many theories as to the mechanism of production of such ulcer recurrences amongst which is the Shwartzman²⁰ phenomenon. Bacterial invaders in previous ulcers may be responsible for a state of reactivity in the gastric tissues. With fresh infections of the nose and pharynx bacterial toxins are produced and may become the provocative agents in producing necrosis in gastric areas of reactivity. The incidence of hemorrhage as an initiatory symptom in recurrence of ulcer favors the idea of the Shwartzman phenomenon.²¹

The patient who comes into the office complaining of loss of appetite, lack of pep, morning nausea, sometimes vomiting and a "lump" or a gummy secretion in his throat is a common occurrence. Examination discloses, as a rule, no single sinus involvement, but a productive inflammatory condition

of several of the sinuses. These cases used to be therapeutic problems in my hands until I placed them on self nasal irrigations at home combined with initial office treatments consisting of Proetz displacement sinus irrigations. The idea of self-irrigations by the patient meets with the opposition of many otolaryngologists who warn of the possibility of spreading the infection to uninvolved sinuses and to the ears via the Eustachian tubes. Precaution against this possibility is taken in instructions given the patient. He is told to use a ½% or 1% aqueous solution of ephedrine ten to fifteen minutes before the irrigation. Before he proceeds he is to make sure that he can breathe clearly through each nostril. A simple irrigating apparatus, such as the Whitall Tatum, is used. The irrigating solution consists of one-half teaspoonful of salt and one-half teaspoonful of baking soda to the pint of water as warm as the patient can stand. In the beginning, the irrigations are done twice daily, then gradually reduced in frequency. This simple regime is amazingly successful.

As for the eye, in the realm of which I claim no experience, certain of its disorders must be borne in mind as producing symptoms confined to the gastrointestinal tract. Indigestion and constipation, flatulence and vertigo are mentioned by de Schweinitz²² as reflex disorders resulting from astigmatism or other refractive disorders. Vertigo, nausea and vomiting may originate in paralytic strabismus.

Szokolik²³ mentions retro-bulbar hemorrhage as causing repeated vomiting and slowing of the pulse (Aschner's syndrome).

Impressive are the reports of Glaser and Lerner²⁴ who completely relieved the symptom complex of cyclic vomiting in five children whose ages were 25 months, 2½ years, 3, 6, and 7 years, by the fitting of glasses. They believe that in cases of cyclic vomiting of undetermined origin, refraction should be performed after the use of atropine, regardless of the age of the patient.

These disorders of the eye, ear, nose and throat barely skim the surface, but may prove reminders to the practitioner who is constantly harassed by mimics of gastro-intestinal diseases.

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THE DIAGNOSIS OF CANCER OF THE STOMACH AND COLON

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The Author. M.D. *Harvard*, 1924. M.S. *Yale*, 1929.
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THE DIAGNOSIS of cancer of the gastro-intestinal tract is becoming of increasing importance, first, owing to the increased incidence of cancer and, second, because of the growing realization of the inadequacy of modern medical methods to cope with the problem. The scope of the problem may be indicated by the fact that approximately half of all cancer is in the gastro-intestinal tract and more than half of this is in the stomach.

The effectiveness of medical and surgical measures in dealing with cancer of the gastro-intestinal tract has been variously estimated according to the group selection of those afflicted with this disease. With a few exceptions most reports deal with those patients entering specialized institutions or services and there is very little data available as to the effectiveness of therapeutic measures in total communities. A study of metropolitan New Haven indicates that not more than 2% of patients with cancer of the stomach are living at the end of five years. Cancer of the large intestine presents a more hopeful picture. Approximately 15% of these were found living at the end of five years. However, it should be emphasized that, of the patients surviving radical excision, the findings are much more encouraging and give some indication of what may be reasonably expected in the treatment of these diseases. Those patients surviving radical removal of the stomach have a 25% chance of surviving five years and those having a radical removal of tumors of the colon have a 60% chance of surviving five years. These five year cures, 25% and 60% respectively, are obtained in a group of patients in whom late diagnosis is all too common. Comparatively few patients with cancer of the gastro-intestinal tract are operated on before local metastasis has occurred. As earlier diagnosis becomes more frequent more favorable cases will be seen in

which radical surgery may result in a cure and the results of treatment will be even more encouraging. It has been frequently said that cancer of the gastro-intestinal tract is a surgical problem. However, Charts I and II indicate that when viewed from the

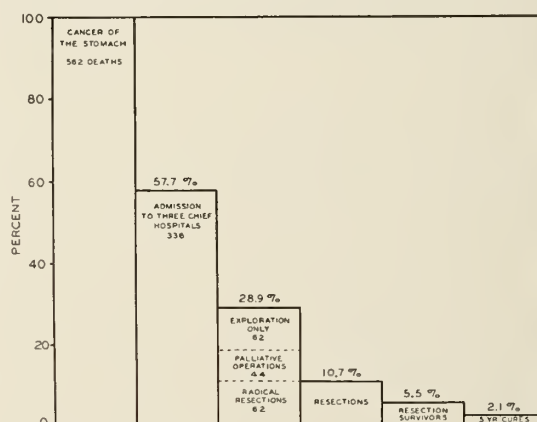
FATE OF ALL PATIENTS WITH CANCER OF THE STOMACH
METROPOLITAN NEW HAVEN 1931-38

CHART I

Note that an attempt at cure could be made in only 10 per cent. Ninety per cent of cancer of the stomach is a medical diagnostic problem.

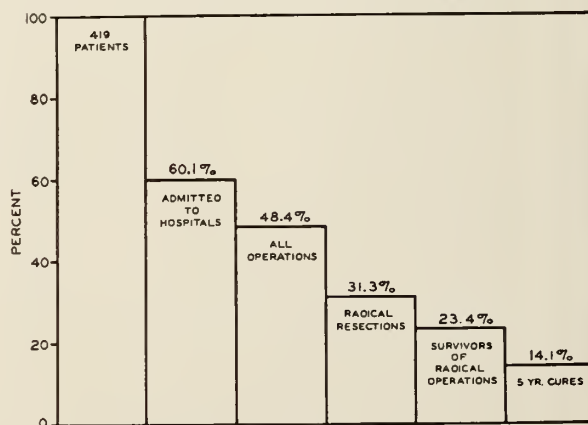
FATE OF ALL PATIENTS WITH CANCER OF THE COLON
METROPOLITAN NEW HAVEN 1921-31

CHART II

Note that an attempt at cure could be made in 31 per cent. Seventy per cent of cancer of the colon is a medical diagnostic problem.

From a symposium on Gastro-Enterology presented at the Annual Meeting of the Connecticut State Medical Society, Hartford May 22-23, 1940

standpoint of the total disease in the community it is still chiefly a medical diagnostic problem.

Why are medical measures so ineffective in dealing with these diseases? Situated as they are in the interior of the body the presence of early cancer is made known to the patient only by a derangement of function. This alteration of function does not usually lead early to a suspicion of cancer, but rather it is attributed to some functional disorder. The most common error in both cancer of the stomach and cancer of the colon is late diagnosis—so late that the cancer has already spread from its local origin. Not more than two or three per cent of cancers of the stomach and twenty per cent of cancers of the colon are diagnosed before metastases have occurred. The responsibility for this late diagnosis is shared about equally by patients and physicians. For the patients the problem is chiefly one of education so that they will call on their physician for assistance earlier in the course of the disease. The most common error among physicians is failure to utilize the x-ray and other laboratory aids at their disposal. It is likely that a chief reason for the failure to use modern laboratory methods is based on the erroneous assumption that cancer of the gastro-intestinal tract may be diagnosed clinically by the signs and symptoms alone. It may in some instances be so diagnosed, but seldom in time to give the patient a chance of cure.

It is now generally accepted in the literature that there is no symptom complex characteristic of cancer of the stomach. This is particularly true in the early stages of the disease when the protean symptoms usually no more than arouse a suspicion that a cancer may be present. It is for this reason that so many patients either do not seek medical advice or treat themselves with the aid of the corner drug store. It is also for this reason that many patients, first consulting a physician in the early stages of the disease, are frequently treated for functional disturbances of the gastro-intestinal system.

Since cancer of the stomach can be diagnosed only with the aid of x-ray,* the problem resolves itself into when x-rays of the gastro-intestinal tract should be done. No one knows better than the general practitioner that he is not justified in advising a gastro-intestinal series on every patient with a gastro-intestinal complaint. It is equally apparent

*The value of the gastroscope is discussed in another paper.

CUMULATIVE CHART—INTERVAL FROM ONSET TO FIRST VISIT TO PHYSICIAN COMPARED WITH TOTAL DURATION OF SYMPTOMS TO ADMISSION TO HOSPITAL 125 PATIENTS

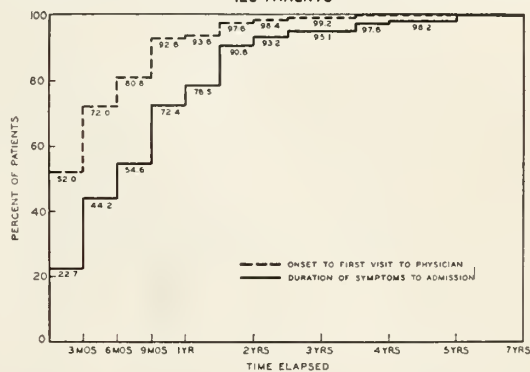


CHART III

Cancer of the stomach. Note that only 22.7 per cent of these patients were admitted to a hospital within three months.

DELAY IN DIAGNOSIS OF CANCER OF THE COLON

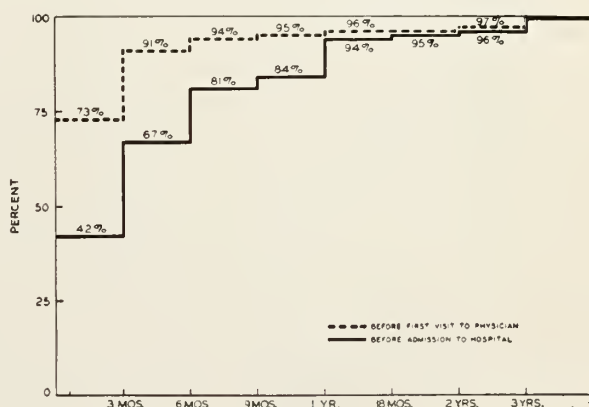


CHART IV

Forty-two per cent were admitted to a hospital within three months; nearly twice as many as in cancer of the stomach (Chart III), yet the cure rate is seven times as many as cancer of the stomach (Charts I and II).

that he is not justified in treating a patient with a chronic gastro-intestinal complaint without first ruling out an organic lesion with the aid of x-rays.

It has been emphasized by many writers on this subject that there is undue delay in the diagnosis after the patient has first visited his physician. This delay has been variously estimated depending upon the arbitrary time limit which has been set within which a diagnosis should be made. In Chart III this limit has been arbitrarily placed at three months and it was found that nearly 50% of patients were

over this limit. However, many of these patients saw a physician when their symptoms were undoubtedly so well developed that a diagnosis should and could have been made within three weeks rather than three months. The *duration of symptoms* when the patient first visits a physician is of the greatest importance in determining whether an x-ray examination is immediately indicated. If these symptoms are progressive, it is still more urgent. *It is suggested that any gastro-intestinal symptoms of more than one month's duration should be considered as chronic and it is unsafe to treat such a patient without x-ray and laboratory examinations.*

It is recognized that cost is a frequent consideration which may influence a decision as to whether an x-ray examination is done. It is frequently assumed that a negative x-ray is a waste of money. On the contrary, it should be considered an insurance, and an x-ray to demonstrate incurable cancer as a waste of money.

Laboratory tests and other criteria may also give further assistance in determining the urgency of x-ray examination. The value of gastric analysis has been questioned. Nevertheless, gastric analysis seems to have been established as the most reliable laboratory test indicating the possibility of gastric cancer. It is of particular value in distinguishing between gastric ulcer and cancer (Chart VII). However, the test is by no means infallible. Seventy per cent of patients with gastric cancer have no free HCl, eighty to ninety per cent have either a low or absent free HCl. Low or absent HCl does not mean that such a patient has a cancer of the stomach. However, statistically such a patient is more likely to have a cancer of the stomach. Likewise, it is less likely that the symptoms are due to ulcer although a few ulcer patients may have a low acid. It is hazardous to treat a patient in the cancer age for ulcer without an x-ray examination. It is many times more dangerous to treat such a patient for ulcer if the gastric acidity is low or absent. Blood in the stool (positive Guaiac) is found in two-thirds of the patients. Its absence is of no significance. Anemia below 4,000,000 and a hemoglobin below 70% is found in half of the patients, but likewise the absence of anemia has no significance. The age of the patient is statistically also of significance in determining the probability of cancer of the stomach. Ninety-five per cent of cancer of the stomach occurs in patients over 35 years and 90% in patients 40 or over. While all of these criteria may be of no value

CARCINOMA OF THE STOMACH INITIAL AND ADMISSION SYMPTOMS

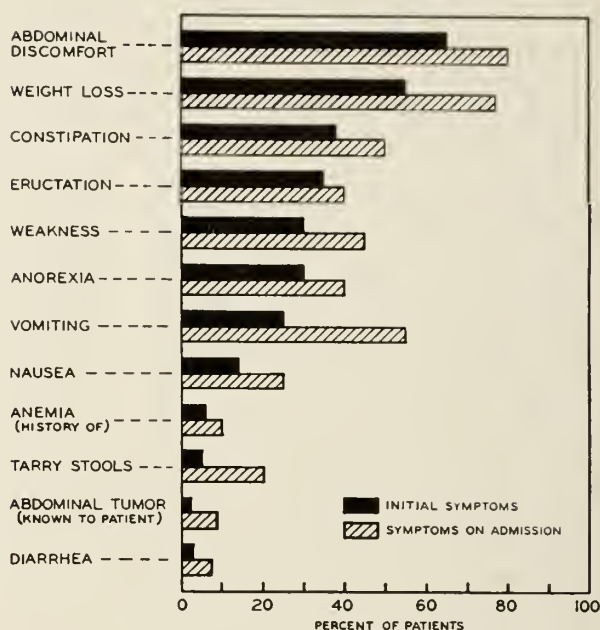


CHART V

Note that only two symptoms, abdominal discomfort and weight loss, are present in more than half of the patients.

CARCINOMA OF THE COLON (EXCLUDING RECTUM) INITIAL AND ADMISSION SYMPTOMS

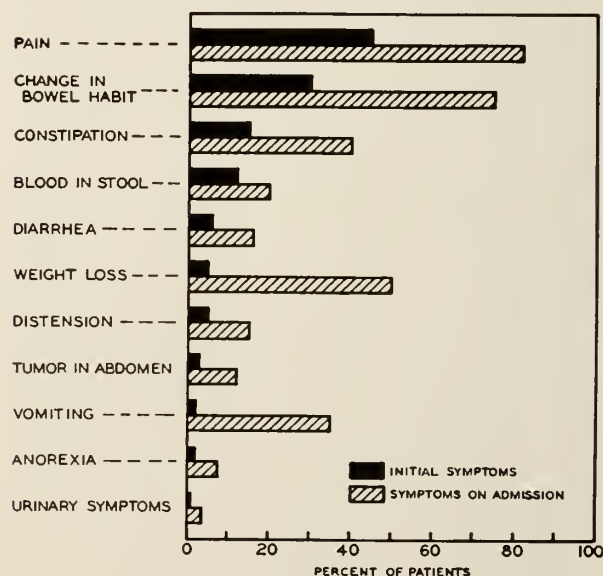


CHART VI

Note that early in the disease the most common symptom is found in only 40 per cent of patients.

in the individual case yet they are unquestionably of statistical value in determining whether further investigation is needed, i.e., the finding of a high gastric acidity indicates that the chances are not more than two out of ten that the lesion is cancer of the stomach. If the patient is under 35 years, the chances of cancer are still further diminished, etc. While such statistical exclusion methods alone would improve the results of cancer of the stomach several hundred per cent, nevertheless, the individual patient may not wish to undergo this risk.

Cancer of the colon** presents very much the same problem as cancer of the stomach. Here, too, the early symptoms are protean and ill-defined and x-ray is indispensable in the diagnosis. It is significant that there is less delay due to the patient with cancer of the colon and the results are correspondingly better than those in the stomach. Only 25% of patients with cancer of the stomach have visited a physician within three months of the onset of their disease whereas 75% of those with cancer of the colon have visited a physician within three months. Pain is a more prominent symptom in cancer of the colon (83% on admission to the hospital) and this may account for the more expeditious diagnosis. Nevertheless, nearly 60% of patients with cancer of the colon have had symptoms for more than three months before admission to the hospital and three-fourths of them already have metastases.

Cancer of the colon cannot be diagnosed in the early stages by the signs and symptoms alone. Like cancer of the stomach the presenting symptoms may only arouse a suspicion that a cancer is present. In fact, these symptoms may be so vague as to make it impossible to determine whether the cancer is in the stomach or the large bowel.

Again, symptomatic treatment or diagnosis of a chronic complaint without x-ray studies is unsafe. Laboratory tests are of comparatively little value in the diagnosis of cancer of the colon unless they are positive. Even then they give no indication as to the location and character of the lesion. Occult blood in the stool is a clear indication for further study but its absence is of no diagnostic influence. Sigmoidoscopic examination should be done as many

**Colon in this paper is defined as that part of the large intestine in which tumors may be removed by the trans-abdominal operation. It does not include those of the rectum or rectosigmoid junction requiring a combined abdomino-perineal or perineal operation. Such tumors are better diagnosed with a sigmoidoscope than by x-ray.

GASTRIC ANALYSIS: FREQUENCY DISTRIBUTION OF FREE ACID VALUES AFTER HISTAMINE

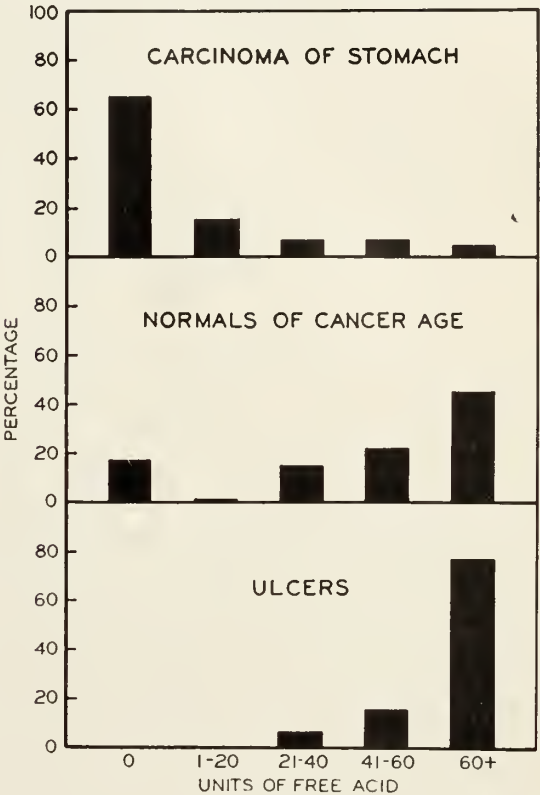


CHART VII

of these tumors may be seen through the sigmoidoscope. It is suggested that a change in bowel habit of one month's duration with or without anemia or occult blood in the stool deserves x-ray examination.

SUMMARY

1. One-half of all cancer is found in the gastrointestinal tract.
2. The effectiveness of medical methods in dealing with this problem should be measured with reference to the total disease existing in the community. The effectiveness of medical methods in cancer of the stomach is 2% and colon 15%. However, the cure rate in those patients diagnosed early enough for radical excision is encouraging: approximately 25% for stomach and 60% for colon.
3. The greatest potential improvement can be brought about by shortening the delay in diagnosis. The physician and patient alike share this responsibility.

(Concluded on page 527)

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

CLINICAL CONSULTATIONS AND HOSPITAL CARE SERVICES IN A MATERNAL AND CHILD HEALTH PROGRAM

MARTHA L. CLIFFORD, M.D., *Hartford*

THE NEED FOR more and better medical care for people in the lower-middle income group has been recognized for years. The rich and the poor already benefit by modern medical science, but the low wage earner cannot pay for treatment which requires laboratory tests, x-rays and hospital care. The Connecticut State Department of Health through its Bureau of Child Hygiene is taking an active part in attempting to solve the problem of medical care for obstetric and pediatric cases in families which are medically indigent by offering clinical consultations to family physicians in charge of such cases and by paying for hospital care wherever necessary.

Nearly three years ago, a service providing clinical consultation to family physicians for their obstetric cases was started through the united efforts of the Connecticut State Medical Society and The Connecticut State Department of Health. The purpose of this service was to make it possible for physicians to obtain skilled obstetrical consultation for abnormal or borderline cases who otherwise would not be able to secure this type of care. It has seemed that a service providing pediatric consultation, also a means of paying for necessary hospital care for both obstetric and pediatric cases occurring in medically indigent families, would be most worth while.

Source and Use of Funds:

In connection with the 1939-40 Connecticut State Plan for Maternal and Child Health Services, a request was made to the United States Children's Bureau for funds to pay for clinical consultations and for hospital care of obstetric and pediatric cases referred by the clinical consultants. The funds avail-

able are insufficient to assume payment of consultation fees and the hospital bill of all cases occurring in medically indigent families in the State. It is felt that in cities with a population greater than fifty thousand, residents have better access to clinical facilities than do patients living in smaller communities. To be eligible for the consultation service, a patient must be a resident of a town having a population of less than fifty thousand and must be self supporting but unable to pay for medical care. Financial eligibility of each case is determined by the family physician who finds out, if he does not already know, whether the case is on town aid or is unable to pay medical expenses. Consultation fees are paid upon receipt of the appropriate form signed by the attending physician and the consultant. A fee of \$5.00 is paid for a consultation in the consultant's office, while a fee of \$10.00 is paid for a consultation which requires the consultant to travel to the patient. A maximum of \$20.00 for consultation fees is allowed for each case. Consultants are reimbursed for travel at the rate of five cents per mile. If transportation of the patient to the hospital requires an ambulance, the charge will be paid at a stated rate by the Bureau of Child Hygiene. Hospital bills for the patients, who are placed on ward service, will be paid at previously arranged rates either on an all inclusive per diem rate, or at a basic per diem rate plus extras. Consultants may authorize hospital care for the first four days, while approval of extension of hospitalization rests with the Director of the Bureau of Child Hygiene. Investigation of cases hospitalized may be necessary in certain instances. No patients except premature infants will be accepted for hospital care unless hospitalization has been recommended by an obstetrical or a pediatric

Director, Bureau of Child Hygiene

Presented at the third session of the Maternal Child Health Association, October 10, 1940

Section of the 69th Annual Meeting of the American Public

consultant. It should be emphasized that except for premature infants, cases accepted for hospital care are those whose family physician has requested consultation and for whom the consultant has recommended hospitalization. In those instances where the consultant has been called by the family as its family physician, no consultation fee is available, but the consultant may authorize hospital care. Cases already in the hospital are not eligible for hospital care under Bureau of Child Hygiene funds.

Appointment of Consultants:

Consultants are appointed following their recommendation by the Public Health Committee of the State Medical Society. It has seemed expedient to require one classification of qualifications for physicians practicing in urban centers and another for physicians practicing in towns having a population of less than fifty thousand. Since May 1, 1940, the policy has been to appoint physicians who meet the following requirements:

Physicians practicing in cities or groups of towns where the population is greater than fifty thousand must be certified by the American Board of Obstetrics and Gynecology or certified by the American Board of Pediatrics.

Physicians practicing in cities or groups of towns where the population is less than fifty thousand must have had one year's rotating internship and at least one year's hospital training in obstetrics or pediatrics plus five years' service on the obstetric or pediatric staff of the local general hospital; or consideration will be given to physicians who have taken a year of graduate work in their specialty, or who have been responsible for the obstetric or pediatric service of the local general hospital for ten years or more, providing the record of that hospital is satisfactory.

How Consulting Services Function:

A physician in charge of an obstetrical or pediatric case, feeling that consultation is desirable, calls a consultant on the list received from the State Department of Health and asks him to see the case. The consultant makes an examination and gives his recommendation for treatment to the attending physician. Consultation may be had for obstetric patients at any time during pregnancy, at the time of delivery, or during the postpartum period. For pediatric patients, the attending physician may call a pediatric consultant for any infant or child under sixteen years of age who is acutely or chronically ill and who presents a diagnostic or therapeutic problem.

Provision for Hospital Care:

If treatment recommended by the consultant requires hospitalization, and the attending physician agrees, the patient is sent to the nearest approved hospital. The form signed by the consultant authorizing hospital care for the first four days should accompany the patient to the hospital. The patient is placed on ward service. If the hospital stay is expected to be longer than four days, the superintendent requests extension of hospitalization on a form provided for that purpose. No consultation fees are paid for patients while on ward service, but provision is made for all necessary x-rays and laboratory tests.

Hospital Standards:

Hospitals approved for care of obstetric or pediatric cases must meet definite standards. Since the State Department of Health licenses maternity hospitals according to minimum requirements in the Sanitary Code, it has been necessary to designate only a few additional requirements for maternity hospitals approved for care. For hospitals approved for care of pediatric cases, a complete set of standards has been set up.

Hospitals wishing to be eligible for hospital care services, in order to be paid a per diem rate for obstetric cases, must meet the requirements of the Sanitary Code and in addition must have on their obstetrical staff a physician who has been appointed as an obstetrical consultant. The attending staff and obstetrical consultants shall make a thorough review and analysis of the obstetric work done in the hospital, at least monthly, with particular consideration to all deaths (maternal, neonatal and stillborn) and morbidities and complications. Facilities must include x-ray equipment and trained personnel, an operating room equipped for performing major surgical operations, a laboratory for blood counts, hemoglobin determinations, typing and cross-matching of blood, for blood chemistry, for bacteriological examinations, and equipment necessary for giving blood transfusions, and ambulance service available throughout the area served by the hospital. Furthermore, it is recommended that the hospital require that a consultation be held with a specialist in obstetrics prior to any major obstetrical operation and for the treatment of serious complications of pregnancy.

Hospitals approved for the care of infants and children under sixteen years of age are required to meet certain standards and those approved for the

care of premature infants as well must meet additional standards.

The requirements for hospitals approved for the care of infants (not including premature infants) and children under sixteen years of age include:

The pediatric service shall be under the supervision of a staff including at least one physician who has been appointed as a pediatric consultant; the attending staff and the pediatric consultants shall make a thorough review and analysis of the pediatric work done in the hospital, at least monthly, with particular consideration to causes of deaths and illnesses; a registered nurse shall be in attendance at all times; the building, equipment and surroundings shall be kept clean at all times, and the management and operation of the hospital shall be such as reasonably to ensure the health, comfort and safety of the patients; the buildings, equipment and precautions taken to provide for the safety of patients and employees in case of fire must meet the approval of the State Commissioner of Health; adequate facilities must be available for the isolation of children with evidence of infection; the equipment of the operating room shall be adequate for the performing of major surgical operations; adequate laboratory facilities must be available for blood counts, hemoglobin determinations, typing and cross-matching of blood, urinalyses, blood chemistry, bacteriological examinations, routine pathological examinations; adequate facilities for giving blood transfusions; facilities for supplying oxygen and apparatus for its continuous administration; x-ray equipment and trained personnel; accurate and complete medical records including history, physical examination, laboratory data and records of treatment; ambulance service available throughout the territory served by the hospital. In addition it is recommended that pediatric patients be segregated from other patients.

The additional standards required of hospitals approved for the care of premature infants include:

A separate nursery, or other facilities, providing segregation in a suitable environment for premature infants; a registered nurse and preferably one with special training in the care of premature infants in

attendance at all times; no member of the nursing staff that cares for premature infants may attend other patients who may have infections or contagious diseases; one incubator for every ten or less bassinets; a nursery equipped with means for maintaining a constant temperature of 75° to 80° F. and with some means for humidifying the room up to 55 or 65 per cent; hospitals accepting a premature infant born outside the hospital must provide a suitable nursery and isolation facilities on the pediatric service for its care, and the hospital shall be provided with a portable incubator for use in transferring premature infants from the home to the hospital.

It is recommended that all hospitals refer the cases hospitalized under the Obstetrical or Pediatric Consulting Services to local public health nursing organizations so that the home may be prepared for the patient's arrival and so that there may be nursing supervision of the patient in the home.

SUMMARY

1. A program of clinical consultations in obstetrics and pediatrics and of hospital care services is being carried on by the Connecticut State Department of Health in coöperation with the Connecticut State Medical Society and the Connecticut State Hospital Association.
2. The services are limited to patients of borderline economic level, living in towns of less than fifty thousand population.
3. Qualifications for consultants are specified.
4. The consultant is called directly by the attending physician.
5. The consultant is paid a nominal fee.
6. The financial eligibility of each case is determined by the family physician.
7. Hospital care may be recommended by the consultant.
8. Hospitals approved for care must meet certain requirements.
9. In certain instances it may be necessary to investigate cases hospitalized.

DRIP! DRIP! DRIP! — Doctors and surgeons everywhere are enthusiastic about the new "DryBrow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "DryBrow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.

SEVENTEENTH CLINICAL CONGRESS

of the

Connecticut State Medical Society

NEW HAVEN, SEPTEMBER 16, 17, 18, 1941

The registration fee for the 1941 Congress will be \$2.00. This fee admits to all sessions of the Congress except the special course. Just as last year, both morning and afternoon sessions will be held at the Sterling Law Buildings.

Luncheon will be served, at a moderate price, in the Law Buildings each day. One or more of the guest speakers will address the Congress at each of these luncheons.

Having in mind the possibilities of the existing emergency, the program committee is presenting a course in traumatic surgery, to be given on the afternoons of Tuesday, Wednesday, and Thursday, September 16, 17, and 18, at 4:30 P. M. and weekly intervals thereafter until the course has been completed. A member of the Congress may elect to take this course on payment of an additional fee of \$1.00. The course will be limited as to the number of registrants.

Section meetings are arranged by the individual sections. Later announcements will give details of these meetings.

The Women's Medical Society of Connecticut will hold its fall meeting at the time of the Congress. All women in medicine will be welcome.

Parking of automobiles for members of the Congress will be unrestricted as to time in the vicinity of the meeting place. Continuous telephone service will be maintained.

Early registration will facilitate the work of the committee as well as save time for you at the Congress. Bound into this issue of the Journal you will find a registration card. If you expect to attend the Congress please fill it out now and send it with your check made payable to the Connecticut Clinical Congress. This should be sent to the office of the Connecticut State Medical Society, 258 Church Street, New Haven.

MAURICE J. STRAUSS, M.D.

*Chairman of the Committee on Publicity
and Registration.*

PROGRAM

Tuesday, September 16

- 9:30 A. M. Treatment and Nation-wide Control of Gonococcal Infections
Oscar F. Cox, Boston, Massachusetts
- 10:00 A. M. Cancer of the Cervix
Speaker to be announced
- 10:30 A. M. Female Hormones in Clinical Medicine
Emil Novak, Baltimore, Maryland
- 11:00 A. M. Urethritis in Women
Charles L. Larkin, Waterbury
- 11:10 A. M. Irregular Bleeding in Women Means Immediate Examination
Arthur H. Morse, New Haven
- 11:20 A. M. Treatment of a Cystic Cervix by Cauterization
James R. Miller, Hartford
- 11:30 A. M. Indications and Contraindications for Medical Induction of Labor
Donald A. Bristoll, New Britain
- 11:40 A. M. Male Hormone Substances: Their Effects and Limitations in Therapeutic Doses
John M. Hamilton, New Haven

12:00 — 2:00

Luncheon

EMIL NOVAK, *Speaker*

- 2:00 P. M. Treatment of Compound Fractures
Speaker to be announced
- 2:30 P. M. The Best Method of Examining a Back
James L. Poppen and Gilbert E. Haggart, Boston, Massachusetts
- 3:00 P. M. Treatment of Fresh Wounds: Chemotherapy, Closed Plaster, etc.
Robert H. Kennedy, New York City
- 3:30 P. M. The Immediate Treatment of Head Injuries
E. Jefferson Browder, Brooklyn, N. Y.
- 4:00 P. M. X-ray Demonstration — Craniospinal Injuries
Hugh Wilson, New Haven
Demonstration of Essentials of a Neurological Examination for the General Practitioner
Y. D. Koskoff, Pittsburgh, Pennsylvania
- 4:30 P. M. Special Course in Traumatic Surgery

1941 CLINICAL CONGRESS

- ☐ Registration Fee for Clinical Congress..... \$2.00
☐ Additional Fee for Course in Traumatic Surgery \$1.00

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The Connecticut Clinical Congress, 258 Church Street, New Haven, Conn.

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City..... State.....

OFFICE USE

No.	Date	1940	Prev. Cong.	State Member
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Wednesday, September 17

- 9:30 A. M. Physical Defects in the General Population
George St. J. Perrott, Bethesda, Maryland
- 10:00 A. M. Hypertension
Irvine H. Page, Indianapolis, Indiana
- 10:30 A. M. What is Arteriosclerosis
Milton C. Winternitz, New Haven
- 10:45 A. M. A New Diagnostic Sign in Myocardial Infarction
Peter Steincrohn, Hartford
- 11:00 A. M. Predisposing Factors in Myocardial Infarction
Ernst P. Boas, New York City
- 11:30 A. M. Modern Treatment of Congestive Heart Failure
Samuel A. Levine, Boston, Massachusetts

12:00 — 2:00

Luncheon

ERNST P. BOAS, SAMUEL A. LEVINE, IRVINE H. PAGE and MILTON C. WINTERNITZ, *Speakers*

- 2:00 P. M. Recent Developments in the Treatment of Deafness
Frank D. Lathrop, Boston, Massachusetts
- 2:30 P. M. Diagnosis and Treatment of Bleeding from the Stomach
Burrill B. Crohn, New York City
- 3:00 P. M. Good and Bad Aspects of Gold Therapy in Arthritis
John R. Paul, New Haven
- 3:15 P. M. The Value of X-ray Therapy in Postoperative Parotitis
Daniel C. Patterson, Bridgeport
- 3:25 P. M. Bronchial Adenoma
Gustaf E. Lindskog, New Haven
- 3:40 P. M. Office Treatment of Mild Depression
Vera Stevenson, New Haven
- 3:50 P. M. How to Overcome the Smoking Habit
Eugen Kahn and Edwin F. Gildea, New Haven
- 4:00 P. M. X-ray Demonstration — Heart Disease
Hugh Wilson, New Haven
- Demonstration of the Technic of Performing a Cardiac Examination
Samuel A. Levine, Boston, Massachusetts
- 4:30 P. M. Special Course in Traumatic Surgery

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(SEE PAGE 2)

Thursday, September 18

- 9:30 A. M. Treatment of Virus Infections
Thomas Francis, Jr., New York City
- 10:00 A. M. New Sulphonamide Drugs and Their Uses
Joseph F. Sadusk, New Haven
- 10:20 A. M. Streptococcal Fever, Scarlet Fever and Streptococcosis
James D. Trask, New Haven
- 10:40 A. M. Vaccines for Influenza
Francis G. Blake, New Haven
- 10:50 A. M. Methods of Resuscitation
Howard W. Haggard, New Haven
- 11:00 A. M. Diagnosis and Treatment of Brain Abscess
Bernard S. Brody, New Haven
- 11:15 A. M. Management of a Patient with a Subarachnoid Hemorrhage
William J. German, New Haven
- 11:30 A. M. Estimation and Management of the Bad Surgical Risk Case
Frank H. Lahey, Boston, Massachusetts

12:00 — 2:00

Luncheon

FRANK H. LAHEY, *Speaker*

- 2:00 P. M. Mouth Tumors
Grantley W. Taylor, Boston, Massachusetts
- 2:30 P. M. Gastro-intestinal Allergy
Matthew Walzer, Brooklyn, N. Y.
- 3:00 P. M. Nutritional Deficiencies in Surgery
Sammel C. Harvey, New Haven
- 3:30 P. M. Modern Treatment of Burns
Jerome T. Webster, New York City
- 4:00 P. M. Demonstration on Foot and Ankle Problems
- 4:30 P. M. Special Course in Traumatic Surgery

COURSE IN TRAUMATIC SURGERY

SEPTEMBER 16, 17, AND 18, AND WEEKLY THEREAFTER

SAMUEL C. HARVEY, NEW HAVEN AND OTHERS

- A. General Principles in the Treatment of Wounds
- B. Craniocerebral Injuries
- C. Spinal Injuries
- D. Injuries to the Chest
- E. Abdominal Injuries
- F. Injuries to the Kidneys and Urinary Apparatus
- G. Maxillofacial Injuries
- H. Injuries to the Eye
- I. Fractures
- J. Injuries to Blood-vessels and Nerves

CONNECTICUT STATE MEDICAL JOURNAL

Owned and Published Monthly by The Connecticut State Medical Society

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month—day of month if weekly—and year.

Used manuscripts will be returned only when requested by the author. Manuscripts should not be rolled. Mail flat.

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NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physicians.

We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS: All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS: Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS: Reprints of papers and obituaries may be obtained from the Editor at cost.

EDITORIALS

A New Leader

A courageous man was inducted into the high office of President of the American Medical Association on June 3 in Cleveland. He knows that few presidents have held or will take office in more uncertain or urgent times and he looks ahead undaunted. In his address of acceptance he urged physicians and all others to set aside the expensive human attribute of failing to face disagreeable facts . . . "to make them easier to live with by deprecating them or not admitting their existence."

"We should all have a conviction concerning the war . . . If we are still in the stage of debate, let it be fair, free, unrestricted and without penalty. We must, and at no late date, however, establish what is to be the policy of this nation."

It is Doctor Lahey's own opinion that we are already committed to a position whether we like it or not. He likes it. "We have dared the dictator; it is too late to appease him, and the word has no meaning in his language. We should arrive at a conviction concerning isolation. Is it right? It is my conviction that it is not. I prefer destruction, if it

need be, to survival in cowering terror. Give me positive commitment rather than compromising unsatisfying safety. If I must face my friends in democracy trying to explain my reasons for seeking dubious safety and leaving them to their fate, I prefer the uncertainties of the hazardous undertaking frankly faced as hazardous and to accept them. It is my opinion that if disaster should overtake us in this hazardous undertaking, it would be no more terrible than what will happen to us if we are to try to isolate ourselves. We shall still have ourselves to live with. This nation has been gallant in the past and it can be gallant again. I do not believe there is a safe course."

There may be those who do not agree with Doctor Lahey, but no one will question the fine quality of his courage.

Doctor Osborn Succeeds Himself

In 1922 Stanley H. Osborn, M.D., C.P.H., was appointed Commissioner of Health for the State of Connecticut. At the expiration of each of Doctor Osborn's terms of office the chief executive of the State has reappointed him and in so doing strength-

ened the development of the health program in this State. Governor Hurley has seen fit to continue the present Commissioner of Health for another six years. The medical profession is grateful for this evidence of wisdom and sound judgment; the people of Connecticut are realizing how valuable to every community in the State is such an experienced Commissioner as Doctor Osborn.

Stanley H. Osborn came to Connecticut in 1920,



STANLEY H. OSBORN

having graduated from Tufts Medical College in 1914 and from Massachusetts Institute of Technology and Harvard University School for Health Officers in 1915. For the following year he was in charge of a field unit in the American Red Cross Sanitary Commission to Serbia and Montenegro during the typhus fever epidemic. In 1916 Doctor Osborn was State District Health Officer for the Massachusetts State Department of Public Health, and from 1918 to 1919 served with the A. E. F. and B. E. F. as Battalion Medical Officer and Division Epidermologist. In 1917 and again from 1919 to 1920 he was epidermologist for the Massachusetts State Department of Health. Coming to Connecticut in

1920 Doctor Osborn served first as Deputy Commissioner of Health and Director of the Bureau of Preventable Diseases. Since 1922 he has served the State continually as Commissioner of Health, being first appointed by Governor Lake and reappointed successively by Governors Trumbull and Cross.

In his persistent diligence, yet withall unassuming manner, Stanley H. Osborn has won the respect and esteem of his medical confreres throughout not only Connecticut but much of the United States. His breadth of vision has never been limited by existing conditions but he has shown himself somewhat of the prophet who, gazing into the Promised Land, sets forth to acquire for others that which his hypermetropic eye has envisaged. Connecticut has indeed been fortunate in enjoying the devoted services of this kindly, yet determined servant of the public. A review of health measures and reforms carried out in this State since 1922 will bear evidence of his executive ability. His own Department of Health, functioning smoothly and effectively, is an outstanding example of efficiency and productivity.

To Doctor Osborn on behalf of the medical profession of Connecticut we extend our heartiest congratulations. It has been said that education begins at thirty and life begins at forty. We would add, the results of successful achievement begin at fifty.

Connecticut Again Leads

By the appointment of a housing engineer in the State Department of Health, Connecticut has taken a leading step toward meeting the increasing demands being made on both State and local health agencies to participate actively in a concerted movement to bring the national housing structure up to an adequate level. The position has been established with the aid of funds available to the State under Title VI of the Social Security Act. The Committee on the Hygiene of Housing will serve in a consulting capacity in connection with this work.

The housing problem is not a new one but it is only during recent months that it has become more and more a matter of concern to health authorities. The Surgeon General of the United States Public Health Service in April 1940 called the attention of State and Territorial Health Officers to the problem of inadequate housing, and reminded them that their own departments "have a tremendous stake in these programs both from the standpoint of physical as well as mental health benefits that may be expected

to derive from improvement in housing conditions."

In September 1940, at a special conference of State and Territorial Health Officers, public health problems arising out of national defense were discussed. At that time much thought was given to the strain on the housing situation being created in areas of industrial and military concentration. Out of this conference there developed a tentative sanitation code, prepared by the Sanitation Section of the Domestic Quarantine Division of the United States Public Health Service. Part of this code deals with the sanitation of habitable buildings. In addition, as a result of the conference, the Public Health Service has carried out special reconnaissance surveys in extra-military and defense industrial areas to determine health and medical care needs in these areas.

There are other groups interested in improving the health aspects of the housing situation. The Division of Public Health Methods of the National Institute of Health at present is engaged in studying the current administrative practices of local health departments in the control of health hazards associated with housing. The Milbank Memorial Fund regards the problem as of basic importance in a broad program of expanding public health objectives. The American Public Health Association at its annual meeting in October 1940 set up a committee on housing in the Health Officers' Section. This committee not only will act as a clearing house for reports and advice on health department activities relative to housing conditions in local areas, but will attempt to show how the health officer can function in clearing up slums and substandard dwellings.

Finally, the National Organization for Public Health Nursing has created a housing committee to serve in a consultant capacity. This action followed the presentation in Philadelphia in May 1940 of a paper on housing and health by our own Doctor C.-E. A. Winslow.

Now Connecticut steps out in front with the appointment of a housing engineer. Improved housing is being dealt with in our large cities, as evidenced by the slum clearance programs now being effected. Public Health programs in Connecticut have been progressive since our present Commissioner of Health received his first appointment 19 years ago. Both to him and to progressive leaders in our State Medical Society we are indebted for this new evidence of intelligent leadership. We point with pride to this leading step taken by our State in an endeavor to bring the national housing structure

up to an adequate level. The improvement of conditions of substandard housing is coming more definitely to be regarded as a public health responsibility and Connecticut is one of the first to accept this responsibility.

The Prenatal Blood Test Law

An act concerning serological blood tests of pregnant women for syphilis, frequently referred to in the press as the "Prenatal Bill," passed the General Assembly but has not yet been signed by the Governor. By the signing of this bill, Governor Hurley will place Connecticut in the group of twenty states where legislation of this nature has been enacted, continuing the fight to eliminate syphilis.

The new law makes Connecticut licensed physicians, beginning on July 1, 1941, primarily responsible for carrying out the provisions of the law. Each physician giving prenatal care to a pregnant woman in Connecticut during gestation shall, in the case of each woman so attended, take or cause to be taken a sample of blood within thirty days from the date of the first examination and shall submit the sample to a laboratory approved by the State Department of Health for a standard serological test for syphilis. Any other person who is permitted by law to attend a pregnant woman in the state but who is not permitted to take blood tests, is required by the provisions of the law to cause a sample of the blood of each woman so attended to be taken by a duly licensed physician within thirty days of the date of the first examination and submitted to an approved laboratory. Physicians and others concerned with the carrying out of the provisions of this new law will receive further detailed instructions in the near future.

Such laboratory tests as are required must be made by the State Department of Health on request without charge. The State Department of Health is authorized to approve laboratories for this purpose as well as to approve the varieties of tests that shall be recognized. Laboratories in city departments of health and in hospitals and institutions, as well as private and commercial laboratories, may apply for approval for performing tests for this purpose.

The laboratory tests that will be recognized as acceptable for prenatal law purposes are the standard serological tests for syphilis that have been evaluated in National Evaluation Studies and that have been recommended as satisfactory by the United States Public Health Service. Serologists and heads of laboratories in whose names approval is

extended must first agree that the particular test in question will be performed under the exact conditions specified by the author and must satisfy the State Department of Health that the test will be performed by a capable serologist and in an acceptable manner.

Section II of the law provides that physicians and others permitted to attend pregnancy cases shall state on the birth certificate or still-birth certificate, as the case may be, whether a blood test for syphilis has been made during the pregnancy upon a specimen of blood taken from the woman who bore the child for which the certificate is filed and, if made, the date when such test was made. If the test has not been made, then the reason why each test was not made must be stated. It is provided that in no event shall the birth certificate state the result of the test.

This new law is intended to prevent the birth of syphilitic children and to eliminate the occurrence of stillbirths as the result of syphilitic infection. It supplements the premarital law by protecting the child of parents who have moved into Connecticut from a state where the benefits of a premarital law are not available to its citizens. It will also be a protection to the child of parents who may have been infected with syphilis subsequent to marriage.

This law was introduced into the General Assembly through the efforts of the State Medical Society. It was due to the efforts of physicians and activity on the part of the State Medical Society that the law was passed.

Doctor Klumpp Goes to A. M. A.

Theodore G. Klumpp, M.D., chief of the Drug Division of the Food and Drugs Administration of the United States, has been appointed Secretary of the Council on Pharmacy and Chemistry of the American Medical Association and Director of the Chemical Laboratory and Director of the Division of Foods, Drugs and Physical Therapy of the A. M. A. In these new capacities Doctor Klumpp succeeds Paul Nicholas Leech, PH.D., who died suddenly on January 14.

Since his graduation from Princeton University in 1924, magna cum laude, Doctor Klumpp has acquired considerable prestige and no little fame in the medical world. Following his graduation from Harvard Medical School in 1928 he did research and investigation work in the Children's Hospital in Boston, served an internship at the Peter Bent Brigham Hospital and as assistant resident physician in

Lakeside Hospital, Cleveland. Then he accepted the appointment as instructor in internal medicine at Yale University Medical School, associate physician in the New Haven Hospital, chief of the Hematology Clinic and director of the Medical Laboratories in the New Haven Hospital. In 1936 he became assistant clinical professor of internal medicine at Yale. In 1937 Doctor Klumpp accepted the appointment at Washington, becoming chief medical officer and chief of the Drug Division in the Food and Drugs Administration, which is now a part of the Federal Security Administration. He took up his new duties in Chicago on July 1.

It was while a resident of New Haven that Doctor Klumpp became a member of the New Haven County Medical Association and the Connecticut State Medical Society. These memberships he still holds. Doctor Klumpp has been a regular reader of as well as a contributor to the *Journal*. His many friends in Connecticut rejoice with him in his new appointment. The American Medical Association is indeed fortunate in securing the services of a leader in his field.

Another Clinical Congress Approaches

Elsewhere in this issue of the *Journal* may be found the first announcement together with the program of the 17th Clinical Congress, to be held in New Haven, September 16, 17, and 18. Several of the features recently introduced will be continued this year. Particular attention is called to the course in traumatic surgery to be given during the Congress and continued at weekly intervals thereafter, until completed. This course should carry an added appeal at a time when medical defense plans are uppermost in the minds of all.

Little need be said concerning the quality of the speakers or the timeliness of the subjects to be presented. Both speakers and subjects have been chosen by the Program Committee after much careful thought and aided by suggestions from many members of the State Medical Society.

Your applicant blank is at hand and should be filled out at once before you lose this copy of the *Journal* or forget that another Clinical Congress is rapidly drawing near.

Doctor Miller Honored

Doctor James Raglan Miller, one of the delegates from the State Medical Society to the American Medical Association, has been honored with membership on the Committee on Executive Session.

DANBURY HONORS DAVID CHESTER BROWN

It is a good American custom to show admiration in speech and gift for persons who have contributed more than average service to their times. It has been called a democratic method of knighting a superior man, and it was that honor which was paid to our friend David Chester Brown by physicians gathered from all parts of the State on June 11.

The provocation appeared to be the celebration of the 55th anniversary of Doctor Brown's entrance into medicine but actually his legion of friends in Danbury and Fairfield County just wanted to do him honor.

The ceremonies which were held at the Ridge-wood Country Club were arranged by Doctor Frank Gordon, the President of the Danbury Medical Society and were attended by more than 75 physicians. Seated at the speakers' table were Doctor James D. Gold, the President of The Connecticut State Medical Society; Doctor Brown; Doctor Gordon; Doctor Arthur B. Landry, past President of the State Medical Society; Doctor Ralph Crane, President of the Fairfield County Medical Association; Doctor Frank M. Goldys, Secretary of the Danbury Medical Society; Doctor Daniel Sullivan, of New London; Doctor Samuel C. Harvey, Professor of Surgery, Yale School of Medicine, the speaker of the evening; and Doctor Creighton Barker, toast master.

During the afternoon, golf was played and Doctor Goldys presented appropriate trophies to those who had done well and to others who had not been so

successful. After dinner reminiscent and complimentary remarks were made by Doctor Sullivan, New London, Doctor Patterson, Bridgeport, Doctor Crane, Stamford, Doctor Landry, Hartford, Doctor Burlingame, Hartford, Doctor Gold, Bridgeport.

Starting with his birth, a Yankee born in Norfolk, Virginia, during the Civil War, Doctor Harvey reviewed Doctor Brown's productive career, his activities in connection with the Danbury Hospital, his contributions to the nation as an officer in the Surgeon General's office in Washington during the World War, his term as a distinguished Trustee of the American Medical Association, and his years of usefulness to his community.



Doctor Gordon presented Doctor Brown and gave to him a handsome loving cup as a token of affection of his colleagues in Danbury. In accepting the gift, Doctor Brown repeated the poem "The Bridge Builder" and advised his younger friends that they should not depend upon the deans and

older physicians to build bridges for them for when that comes to pass development and advancement in all directions would be stopped and, he said, "It is only by the continuing devotion of every one of us that we can erect those bridges which will take us across the serious things that now confront us."

It was a touching occasion for Doctor Brown, moved a little by justifiable pride but humble in the presence of so many blessings and the tributes of his fellows who love and respect him.

YALE DEDICATES THE NEW MEDICAL LIBRARY

On Sunday, June 15, 1941, President Seymour presented the keys of the recently finished Medical Library at Yale to Dean Francis G. Blake. This event signalized the formal opening of the library at the dedication exercises held on that day. Presided over by Mr. Wilmarth S. Lewis, representing the Yale Corporation, the meeting included the presentation of the new Harvey Cushing Rotunda by Mr. Starling W. Childs and the address of the day by Doctor John Homans of Boston.

The dedication of this great medical library is a significant event in the annals of American Medicine for within its walls are contained some of the world's most extensive medical historical libraries. In particular the Harvey Cushing, the John F. Fulton, and the Arnold Klebs collections have long been noted for their unusual excellence. Of the Cushing collection the medical historian Castiglioni recently said "it represents by unanimous consent the greatest and the most precious of the classics in the field of surgery and anatomy ever brought together by a private person." Other collections equally significant in their respective fields are those of Doctor George M. Smith, Doctor Clements C. Fry, Doctor George Blumer, Doctor Edward C. Streeter and Doctor J. G. Dusser de Barenne.

Built as an addition to the Sterling Hall of Medicine the library consists of two large wings leading from a central rotunda. These wings house the historical and working libraries respectively. The rotunda, known as the Harvey Cushing Rotunda, was presented by the members of Doctor Cushing's class at Yale, celebrating its fiftieth reunion in this year.

Adjoining the rotunda is The Beaumont Room named in honor of Connecticut's notable son Doctor William Beaumont. Here has been hung the recently completed portrait of Beaumont, which was presented to the library by The Beaumont Medical Club. Of equal interest to physicians of Connecticut is the unique collection from early pharmacies and of early weights and measures collected by Doctor Edward C. Streeter.

Perhaps the most impressive thing, as it appeared on this day of dedication, was the completeness of the library itself. One had the feeling, in spite of knowledge to the contrary, that here overnight, like armed Minerva from Jove's brain, a library had sprung into being. However this may seem, it will not be forgotten that these buildings represent another of the great memorials to the late Harvey Cushing. In his address Mr. Lewis recited the early history of the library project and the great importance of Doctor Cushing in its inception. It is pleasing to know that the knowledge of the fulfillment of this one of his many visions came to him, if only by a few hours, before his death. For the true expression of the function of such a library we may also look to him. Speaking at the dedication of the Welch Library Doctor Cushing said: "A library has to be made useful, not as a passive but as a vital force; it has to serve as a common meeting ground where different streams of knowledge may coalesce: a laboratory for the crystallization of ideas perhaps long expressed, out of which process new ideas have their birth: a place, in short, where medicine, once more in contact with the whole family, will imbue them all with the spirit of that ancient phrase: Where there is a love of humanity, there will be love of the profession."

To the physicians of Connecticut then, who are the profession referred to, the opening of this great library will be greeted with acclaim. To those who have learned to draw inspiration for the present out of former times the past is here unrolled before them, and to those who may have specific interests in medical science of the present moment, a great storehouse is open for their use.

The medical profession of Connecticut also will offer their gratitude and praise to those in whose hands was placed the responsibility for the building and completion of the project. These were many, but the work of a few was especially noteworthy and among these should be mentioned Professor George H. Smith, Doctor Stanhope Bayne-Jones, Doctor John F. Fulton and Doctor Francis G. Blake.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

NEW HAVEN

Committee Appointed to Study Attending Staffs at State Institutions

The House of Delegates authorized the President of the Society to appoint a Committee to study the operation of attending staffs at State institutions and the recompense of physicians serving in that capacity. Doctor Gold has appointed to this Committee: Maurice T. Root, West Hartford, Chairman, John D. Booth, Danbury, and C. John Satti, New London. Doctor Root has been the physician to the American School of the Deaf for many years, Doctor Satti was formerly the Secretary of State and Doctor Booth is a consulting surgeon to the Federal Corrective Institution, Danbury.

Amendment to By-Laws Provides for Associate Members

The House of Delegates at its annual meeting approved an amendment to the By-Laws that had been recommended by the Council. The amendment provides for associate members in the Society.

ASSOCIATE MEMBERSHIP

Chapter I, Section 4. Composition of Society shall read: This Society shall consist of members, *associate members*, delegates, guests and honorary members.

Chapter II, Membership, a new Section 2 be added: *Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut, may be elected to Associate Membership in the Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership which shall be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the rights and privileges of the Society except that they may not vote or hold elective office. They may be appointed to serve upon committees and present papers before the*

Society or any of its sections. Associate Members shall pay the current annual dues to the Treasurer and they shall receive the Journal of the Society.....

Study of Revision of the By-Laws to Continue

The special Committee to study and present revision of the By-Laws that was authorized by the House of Delegates in 1940 proposed no amendments to the By-Laws after the first year of its study and upon recommendation of the Council the Committee is continued for another year. The personnel of the Committee remains unchanged; Chairman, D. Chester Brown, Danbury; Charles G. Barnum, Groton; Cole B. Gibson, Meriden; William M. Shepard, Putnam; and Thacher W. Worthen, Hartford.

Council Appoints Committees

Certain of the Society's Committees are appointed by the Council. The Council has appointed these Committees for the year 1941-42.

Committee on Cooperation with Yale School of Medicine

James R. Miller, Hartford
Charles J. Bartlett, New Haven
Creighton Barker, New Haven
D. Chester Brown, Danbury
Daniel Sullivan, New London
Austin Kilborn, Hartford

Committee on Permanent Funds

Charles T. LaMoure, Mansfield Depot
Charles H. Turkington, Litchfield
Hugh B. Campbell, Norwich

Conference Committee with The Connecticut Pharmaceutical Association

Stanley B. Weld, Hartford, Chairman
Walter I. Russell, New Haven
John H. Foster, Waterbury
John C. White, New Britain
William M. Stahl, Danbury

Advisory Committee to Nurses Examining Board

Claude C. Kelly, Hartford
Harry S. Frank, Middletown

Committee to Study Medical Examiner System

Edward H. Kirschbaum, Waterbury, Chairman
Ralph W. Crane, Stamford
Louis P. Hastings, Hartford
Albert J. Robinson, Hartford
Marvin M. Scarbrough, New Haven

Speakers' Bureau

Doctor Arthur Jackson of Washington who is the Chairman of the Sub-Committee on the Speakers' Bureau of the Committee on Public Relations is organizing the Society's Speakers' Bureau for services during next fall and winter.

In the past the Society has received numerous requests from lay organizations, women's clubs, service clubs, parent-teachers associations and other civic groups for speakers to present medical subjects. These requests have most frequently been filled by the Secretary of the Society and a few members who have expressed their willingness, and during the winter at least one such address has been made each week. It is now proposed to organize a speakers' bureau within the Society consisting of members who are competent and willing to make presentations before lay organizations.

It is planned that the Bureau's activities will cover: social medicine; cancer; tuberculosis; industrial medicine; the medical aspects of national defense; medical care and hospitalization; diseases of childhood; Connecticut medical history; general medicine; geriatrics, psychiatric and emotional problems; child welfare.

A list of physicians to be invited to participate in this activity is being prepared and any member who is interested in taking part in this important new objective of the Society is invited to communicate with Doctor Arthur H. Jackson, Washington.

The Connecticut Medical Examining Board

At the request of the Connecticut Medical Examining Board the office of the Board has lately been consolidated with the office of the State Society. There have been no changes in the personnel of the Board but the Secretary of the Society will serve as the Secretary to the Medical Examining Board and

thereby the service and usefulness of the Society to the medical profession in the State is again extended.

Attendance 149th Annual Meeting

The attendance at the 149th Annual Meeting in May in Bridgeport surpassed the number at any previous meeting. 505 members of the State Society registered and 50 non member physicians. In addition there were 218 members of guest organizations and visitors registered. The Society is steadily outgrowing the hotel facilities that are available for its meetings.

Bridgeport Approves

An editorial in the Times-Star, May 20, 1941

HI-YA, DOC!

Today the learned delegates from all parts of Connecticut come to Bridgeport to attend the annual convention of the Connecticut State Medical Society. This is the sort of convention that comes and goes, and usually attracts little attention. It is made up of professional men, who may relax a little but who still are on their dignity, and they come to convention partly to meet old friends, and partly to learn something helpful in their practice.

This year the convention is different. For one thing, the Medical society has a new department of public relations, and it is a good thing, too. The greatest weakness of the medical men always was that a fancy code of ethics supposedly restrained them from telling the public anything of what was going on.

That has been changed somewhat now. Without lowering their professional standards in any way, the doctors, through their Medical society are meeting the public more than half way. The public has shown, in many ways, that it is deeply interested in doctors, and in their work. There is no subject that interests individuals more than their health, and the newspapers recognize this, with their daily health and medical columns.

The doctors have had a bad scare about "socialized medicine." A great many of them are against it, but not many of the profession or of the public either could tell you exactly what the term means. Apparently it is all right to use tax money to employ a public health officer, or to employ school physicians, or school dentists, or to employ a doctor on the public ambulance, or in the isolation hospital,—but to contract with doctors, either with public or private funds, to keep a certain group of persons well—that is "socialized medicine." Maybe it is; but all of us would like to know about the thing more definitely, before stamping it to death.

Meanwhile, the Connecticut State Medical society has been more progressive than most organizations of doctors, in bringing its interests and activities into line with present-day thinking action.

The society is studying the subject itself of offering group health protection and medical care, and a start soon may be

(Concluded on page 540)

THE AMERICAN MEDICAL ASSOCIATION IN CLEVELAND

CREIGHTON BARKER, M.D.

Connecticut was represented at the House of Delegates of the American Medical Association at the Cleveland session by Doctor James R. Miller and Doctor Edward Ottenheimer. Doctor Ottenheimer attended in the place of Doctor George Blumer, the regular Delegate who was detained at home by personal affairs. About 60 Connecticut physicians registered for the sessions and several of them participated in the program of the meeting and Doctor Herbert Thoms was represented in the scientific exhibit with an exhibit on the subject of x-ray pelvimetry.

The House of Delegates was in almost constant session except on Wednesday when a day long recess was taken. Subjects of great importance to American medicine were acted upon.

It will be of interest to Connecticut physicians who are concerned with the organization of a Section for the general practitioner in the State Medical Society that a resolution presented by the Michigan State Medical Society was tentatively adopted for a year by the House of Delegates. The resolution would create a Section for General Practitioners and it means that between now and the meeting of the House of Delegates in June 1942 the 100,000 general practitioners in the country must show sufficient interest in having a section of their own to convince next year's House of Delegates that the organization of the section should be completed.

The Michigan State Medical Society also introduced a resolution urging a more liberal consideration of hospital privileges for general practitioners. The resolution was returned to the Michigan State Society because it was felt that the phraseology did not accomplish the objectives of its proponents.

The National Specialties Boards came in for a good deal of discussion and perhaps criticism. It was suggested that the Council on Education of the American Medical Association had been a little remiss in letting the control of the Specialties Boards slip away from it. A resolution to study the standards and methods of the Boards from the standpoint of giving appropriate cognizance to experience as well as other qualifications was referred to the Board of Trustees.

In executive session the House voted unanimously to recommend to the Board of Trustees that the

American Medical Association appeal the judgment passed on the verdict of guilty in the case of the United States vs. The American Medical Association.

There were several resolutions and much discussion on the subject of medical participation in the national preparedness effort. The deferment in the Selective Service of physicians and medical students was debated at length. A resolution was passed asking for an agency of Government to be known as the Procurement and Assignment Agency for Physicians, to be a division of the Office of Production Management.

The resolution that woman physicians be commissioned into the Medical Corps of the Army, which was ably supported by Doctor Emily Barringer of New York, was sympathetically received but finally not approved because of the necessity for the changing of laws regulating the appointment of medical officers.

The subject of prepaid medical service received almost identical action as it had in the House of Delegates in The Connecticut State Medical Society. The Delegates in Cleveland reaffirmed the belief that the principle of prepayment for medical care justifies the establishment of plans to carry it out and that these plans should be formulated with the guidance and advice of the Bureau of Economics of the American Medical Association. In connection with these prepaid plans discussion seemed to show that further conferences should be had with the various hospital plans in an attempt to clarify policies relative to the service of radiologists, pathologists and anesthetists.

The subject of the "Coroner System" which has lately been discussed in Connecticut was the basis of a resolution calling for the appointment of a committee of three to study the circumstances in States that do not have medical examiner systems. This subject has been under consideration in one way or another by the American Medical Association for several years and it was again referred to the Board of Trustees.

Attendance at the Cleveland session was so large that hotels were not ample to care for the thousands of physicians and guests who attended and it was necessary to provide accommodations on a lake steamer moored beside the municipal pier.

A. M. A. House of Delegates 1941

JAMES RAGLAN MILLER, M.D.

It has often been said that the House of Delegates of the American Medical Association is one of the most perfect examples of representative democracy which can be found anywhere. The opportunities afforded by my first visit as delegate make me believe that that statement is true. It is an extraordinary body of men. Its machinery, with its well integrated bureaus and committees, is geared to a high degree of efficiency. New as well as old projects and committee reports are referred to reference committees appointed from the delegates themselves. These committees hold hearings, deliberate and report to the House, with their recommendations which often have to stand the test of debate on the floor of the House itself before action is taken.

The most vivid impression that I obtained from my first experience as a delegate was that the membership of the House contained a large number of men who had made names for themselves as great physicians, surgeons and scientists. This is no mere aggregation of medical politicians but a group of men, most of whom I knew amounted to a great deal in their own home communities. It was evident to me that many patients trusted their advice on medical matters and that the physicians back home had faith in their ability to assist in expressing the collective wisdom of organized medicine.

Medical Defense was uppermost in the minds of all delegates and none of the reports was studied more closely than that of the Committee on Medical Defense. This committee submitted also a supplementary report which called for the establishment of a central assignment authority which should include representatives of the civilian medical profession. The purpose of such an authority is to prevent confusion and by proper assignment of physicians to enable both civil and military medical needs to be served as completely as possible. This committee's recommendations were adopted and its labors commended fulfilling as they did the promise made by the House of Delegates at its New York meeting one year ago, namely that the medical profession would do its part in the emergency.

The government authority for the selection of physicians, it was suggested in the resolution, should be known as the Procurement and Assignment Agency for physicians for the Army, Navy, Public Health Service, Civilian and Industrial needs of the

nation. Copies of this resolution were to be sent to the President, Secretary of the Navy, and Secretary of War and other officials.

Universal pleasure was expressed at the selection of Doctor James Ewing for the Distinguished Service Medal, and no balloting was necessary to select the new President-elect, Doctor Fred W. Rankin. It was indeed comforting as one looked at Doctor Lahey and Doctor Rankin on the platform to realize that insofar as these two gentlemen are concerned the medical profession is not apt to be "pushed around" much in the next two years.

Of most interest to me personally was the Executive Session of the House where the reports of the trustees and of our attorney, Mr. Burke, were given concerning the government suit against the American Medical Association. It appeared definitely the obligation of the organized profession to clear up many of the uncertainties which still hang like cobwebs from every corner of this court decision. Are we a trade or a profession? This is a question which the Supreme Court alone can answer, if it will, and the House I believe did right in authorizing the trustees and our attorney to pursue the appeal to the court of last resort.

The New President-Elect of the A. M. A.

Doctor Fred Wharton Rankin of Lexington, Kentucky, was chosen president-elect at the annual meeting of the American Medical Association held in Cleveland in June. Those who count him among their friends testify to the wisdom shown in selecting of a man of such ability. Those who have never grasped Doctor Rankin's hand may feel with confidence that Doctor Lahey's successor will fulfill their ideal as the leader for 1942-3.

Graduating from Davidson College in North Carolina in 1905 and from the University of Maryland School of Medicine in Baltimore in 1909, Fred Wharton Rankin attained further training in surgery at University Hospital, Baltimore. He served as assistant demonstrator in anatomy and associate in surgery at his alma mater from 1913 to 1916. From then until he entered upon his present work as surgeon to St. Joseph's and the Good Samaritan hospitals in Lexington, Kentucky, Doctor Rankin has been associated with St. Mary's Hospital, Rochester, Minnesota, University of Louisville School of Medicine, University of Minnesota Graduate School, and the Mayo Clinic. He served during World War I,

attaining the rank of colonel in the Medical Corps Reserve.

Doctor Rankin has served as a member of the Council on Medical Education and Hospitals and is a member of the Committee on Medical Preparedness of the American Medical Association. He was one of the founders of the American Board of Surgery. He is co-author of two books and has written chapters in several medical textbooks and numerous papers on surgical subjects.

Connecticut at the A. M. A. Convention

Barker, Creighton, New Haven.
 Booe, J. Grady, Bridgeport.
 Carter, Gray, Greenwich.
 Carvey, Edward V., Wethersfield.
 Celentano, L. E., New Haven.
 Collins, Joseph O., Waterbury.
 Connolly, Arthur J., New Haven.
 Connor, George M., Plantsville.
 Davis, James E., Hartford.
 Di Stasio, Frank, New Haven.
 Durkee, Ralph E., Jr., Hartford.
 Ewell, John Woodruff, Farmington.
 Foster, Edward W., Meriden.
 Fulton, John Farquhar, New Haven.
 Greenhouse, Barnett, New Haven.
 Hamilton, James B., New Haven.
 Harvey, Joseph L., Waterbury.
 Hennessy, James J., Hartford.
 Knowlton, Millard, Hartford.
 Lawton, R. J., Waterbury.
 Leonard, John C., New Haven.
 Martin, John G., West Hartford.
 Marvin, H. M., New Haven.
 McLeod, Christie, E., Middletown.
 Miller, James R., Hartford.
 Mirabile, Charles, Hartford.
 Morris, Joyce Springer, New London.
 Morse, L. R., Hartford.
 Nelson, Roger B., Waterbury.
 O'Neill, Charles W., Hartford.
 Ottenheimer, Edward J., Willimantic.
 Oughterson, Ashley W., New Haven.
 Pike, Maurice M., Hartford.
 Poole, Allan K., New Haven.
 Robbins, Clarence Loveridge, New Haven.
 Roberts, Douglas J., Hartford.
 Rogers, Platt H., West Haven.
 Ruby, Robert J., Waterbury.
 Sadusk, Joseph F., Jr., New Haven.
 Seibert, Alfred F., Hartford.
 Shepard, W. M., Putnam.
 Sherwood, Henry, Durham.
 Solomon, Charles I., Meriden.
 Soreff, Louis, East Hampton.
 Standish, E. Myles, Hartford.
 Stietzel, Eric E., South Norwalk.
 Strauss, Maurice J., New Haven.

Sword, Brian C., New Haven.
 Talbot, Henry P., Hartford.
 Tovell, Ralph M., Hartford.
 Tracy, F. Erwin, Middletown.
 Trask, James D., New Haven.
 Vestal, Paul W., New Haven.
 Weaver, Bruce S., Stamford.
 Weise, Ellwood C., Bridgeport.
 Wilson, Chas. C., Hartford.
 Wilson, James C., Hartford.
 Woodbridge, Philip D., New Haven.
 Wright, Wm. W., Hartford.

DIET AND BRIGHT'S DISEASE

(Continued from page 501)

rôle. Attempts to replace fluids and electrolytes are usually practiced through parenteral channels. Because of the severe degree of retention of nitrogenous products and the difficult digestion of fats, the diet should consist mainly of carbohydrates.

The considerations here presented indicate that a rational dietary regime for Bright's disease is to be based on the biologic characteristics of the disease. The principles involved in the dietary regimes are few and relatively simple. Of these the most fundamental is that in practice we are treating not the oliguria, the edema, the hypertension, or the uremia, but the patient.

DIAGNOSIS OF CANCER OF STOMACH AND COLON

(Continued from page 509)

4. Cancer of the stomach and colon cannot be diagnosed early by the signs and symptoms alone.
5. The most common error and cause of delay is the failure to make an x-ray examination early in the course of the disease. A high degree of cancer suspicion on the part of the physician is essential.
6. It is unsafe to assume that persistent gastro-intestinal complaints are due to functional disturbances unless x-ray and laboratory examinations have been done. Even these may require repetition.

A fertile field for the tuberculosis germ is found in workers over thirty years of age. Although the disease is recognized as an occupational hazard of the "dust trade" employees, the occurrence of the disease in other trades is wide enough to warrant the x-ray examination of all workers in all fields of industry.

Kendall Emerson, M.D.

THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President

WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President

HELEN NIVISON, Treasurer

Death of Stamford Hospital Superintendent

George Frank Sauer, Superintendent of the Stamford Hospital for the last nine years and widely known in the East as a Hospital Administrator, died May 17, following a short illness. He will be greatly missed by members of the Connecticut Hospital Association and a host of friends, including members of the New England Hospital Association, the Westchester Hospital Association and the American Hospital Association. In addition, Mr. Sauer was a member of the Stamford Rotary Club, the Stamford Chamber of Commerce and the Polar Star Masonic Lodge of New York City.

A Fellow of the American College of Hospital Administrators, Mr. Sauer came to Stamford from the Lenox Hill Hospital, New York City, where he had served as administrator for fifteen years. Prior to that time he had been Superintendent of the Inwood Rest Tuberculosis Sanatorium for fifteen years and previous to that he was an executive at the Roosevelt Hospital, New York, for approximately ten years.

When Mr. Sauer took over the administration of the Stamford Hospital on October 28, 1932, the daily average number of patients was 134. Today the daily average is in the neighborhood of 194. During the nine years of his superintendency at Stamford he achieved a reputation for efficient changes leading to more effective work and wise expansion. In accordance with his recommendations some of the wards were shifted or rearranged and other alterations were effected, leading toward greater comfort or better care of patients. He paid special attention to enlarging the solariums or porches for convalescent patients. In recent months the extension of the private wing was undertaken representing an important addition to the facilities of the Hospital and giving it a total of sixty-four private rooms.

Those who know Mr. Sauer best will remember him as a Hospital Administrator of sterling character; the people of Stamford recognize that they owe him a real debt; his place in the hospital field will be

hard to fill because of his long experience and outstanding qualifications.

Refresher Course at Backus Hospital

The Refresher Course at the William W. Backus Hospital was started March 4, 1941, and concluded June 2, 1941.

Lectures were given by the doctors of the hospital staff and the faculty of the School of Nursing totaling 75 hours of lectures. They covered medicine, surgery, pediatrics, obstetrics and nursing care. There has been an average attendance of 35. Fifteen are also taking a course in clinical experience of 75 hours. This clinical experience course will continue through the summer.

Defense Preparations at Backus Hospital

The physicians of Norwich and Norwich vicinity have been totally organized and all have expressed their willingness to coöperate, in the event of a catastrophe, as would be seen fit. The hospital has outlined a program whereby approximately 50 more beds could be added to the present capacity. A large quantity of sterile dressings have been prepared and are on hand. Also equipment for the care of fractures has been increased. The nurses have been organized so as to be teamed with the physicians. Refresher courses for registered nurses in the community have been given. Details of this course will be given separately. The hospital has joined with the Connecticut State Police in a careful survey of this whole question. It has also discussed this whole matter with the local Red Cross. The hospital now feels itself in a position to deal to its fullest capacity with any catastrophe that might arise.

REPORT OF SEMI-ANNUAL MEETING

The semi-annual meeting of the Connecticut Hospital Association was held at the Hotel Stratfield, Bridgeport, Connecticut, on May 22, in conjunction with the annual meeting of the State Medical Society.

The meeting was preceded by a luncheon at the Hotel Stratfield with an attendance of 33 members. The meeting

was called to order by Doctor Wilmar Allen, President, at 1:30 P. M.

The minutes of the fall meeting were approved as mailed to the members without further reading.

The Secretary read a detailed report of the activities of the Board of Trustees. Copy attached.

The Treasurer's report was read, accepted and placed on file as follows:

Receipts	
Balance on hand November 1, 1940:	
Birmingham National Bank and Derby Savings Bank	\$1,561.49
Institutional Dues	2,433.06
Personal Dues	337.00
Assessments on 1940 Institutional Dues	109.14
Books—Connecticut Hospital Statutes	25.00
Interest on Savings Account	4.17
Interest on Bond	3.00
Total Receipts	\$4,472.86
Expenses	
Institutional Dues to A. H. A.	\$1,085.59
Personal Dues to A. H. A.	153.00
Personal Dues to N. E. H. A.	64.50
Miscellaneous Expenses, Printing, etc.	174.79
Connecticut State Medical Journal	205.94
Legal Services	500.00
Total Expenses	2,183.82

Balance on hand in Checking Account and Savings Account	\$2,289.04
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Doctor I. S. Geeter, Chairman of the Uniform Compensation Charges Committee reviewed the various meetings held between the insurance carriers, the Trustees and his committee. Little progress had been made towards arriving at a definite rate program. The Committee proposes to present a final proposition to the carriers on the basis of a uniform rate of \$5.00 per day for Room and Board with acceptance for extra charges including Anesthesia and X-ray based on the approved tables from the Anesthesia and Radiology Divisions of the State Medical Society and the balance of special charges in accordance with the accepted New York Schedule. Discussion ensued from the floor and it was the consensus of opinion that some definite decision should be arrived at by August 1.

Voted:

That the report of Doctor Geeter's committee be approved subject to the provision that if the revision rates are not approved by August 1 the member hospitals shall be free to put into effect such rates as they deem wise.

Motion Amended:

Voted amendment to motion that the recommendation in the report be approved subject to the provision that if an agreement with the insurance company is not reached by August 1, the member hospitals will then be at liberty to charge such compensation rates as they deem wise.

At this time Doctor Allen deferred the business meeting to introduce as the speakers for the afternoon program, Commissioner of Police, State of Connecticut, Edward J. Hickey, and Superintendent of Police, City of Bridgeport, Charles

A. Wheeler, whose subjects concerned state and local defense activities. Both speakers gave a very comprehensive outline of the defense program from the angle of state and local development. Following Chief Wheeler's discussion, members of the city police department demonstrated their very modern equipment in conjunction with the local defense program. Upon conclusion of the speakers' remarks, a rising vote of thanks was tendered by the Association.

President Allen reconvened the business meeting and introduced as a delegate from the State Medical Society, Doctor H. Bertram Lambert of Bridgeport. Following his remarks Doctor Lambert made a statement that this meeting was his last official appearance as a delegate.

Doctor Albert Buck, Chairman of the State Defense Committee for the Association submitted the following report:

REPORT OF DEFENSE COMMITTEE

Following a meeting held at New London on November 22, President Allen appointed the following members of the Defense Committee: Miss Anna M. Griffin, Doctor J. Raymond Glazier and Doctor Albert W. Buck.

On January 14 two members of the Committee met with Doctor George M. Smith and Doctor Creighton Barker at the office of the Secretary of the Connecticut State Medical Society.

On March 7 a meeting of the full committee was held at the Charlotte Hungerford Hospital. Following this meeting a questionnaire was prepared which after being reviewed and expanded by the President of the Association, was sent to the thirty-four institutional members under the date of April 9.

By May 6 twenty-one replies had been received. On that date a follow-up letter was sent to those hospitals which had not submitted their statement with a request that they do so immediately. To May 20 the following number of replies had been received—twenty-eight—in summary:

Available number of additional emergency beds or cots	833
Estimated number patients hospitals are apt to receive	1545
Reported medical and surgical staff adequate.....	24
Reported medical and surgical staff inadequate.....	4
Number of additional physicians which would be required in the 28 institutions reporting.....	11
(4 in each of 2 hospitals)	
(3 in one hospital)	

Practically every institution showed the nursing staff inadequate to take the increased load.

All have made certain provisions for additional equipment and supplies.

Number submitting Defense plans either for their individual institution or for the municipalities in which they are located	5
Number submitting no Defense plans	23

The following institutions have not completed and returned the questionnaire or sent a statement of program:

Mt. Sinai Hospital, Hartford
Bristol Hospital
The Hartford Retreat
New Haven Hospital
St. Raphael's Hospital

Respectfully submitted,
Allen W. Buck,
Anna M. Griffin.

Mr. James Hamilton of New Haven supplemented the foregoing report with the statement that 1500 beds and 3000 blankets had arrived in the state and distributed in the following cities: Hartford, New Haven, Bridgeport, Waterbury and New London. This material was received through the American Red Cross. The statement was made that the State Police have agreed to supervise and provide the immediate transportation with the assistance of the Red Cross of the above material to any disaster location in the state. Requests should be made to Sergeant Mulcahy of the Hartford State Police Barracks.

During the discussion that followed it was a consensus of opinion that better coordination should be developed between the various relief agencies and the Hospital Association inasmuch as our State Defense Committee was not aware that this material was available to member institutions.

Mr. Bartine, Chairman of the Committee of the Council on Government Relations, reported briefly on the legislative program stating that the larger House Bill had not at that time been reported out of Committee. (This Bill passed both houses of the Assembly and is now awaiting the signature of the Governor.)

Mr. Bartine stated that in New Haven the problem of hospitalized County cases was causing dissatisfaction. Legislation affecting this problem had been introduced with unfavorable results. Mr. Bartine paid tribute to the splendid cooperation of Judge Thomas in handling the many legislative procedures.

At this time, Mr. James Hamilton reported on the meeting of the state associations held at Chicago in February. The larger subjects discussed at this convention recommended:

1. More meetings based on geographical set-up.
2. An attempt to iron out the differences of opinion between the various hospital plans and the National Association.
3. Direct representation.

The problem of relations with draft boards was also discussed and Mr. Hancock stated that Connecticut was exceedingly fortunate in such relations.

Voted:

That the Board of Trustees be instructed to inform their delegates as to the viewpoint they should take in terms of the new institutional amendments in regard to group hospitalization plans.

The Secretary then read a written report from Honorable James L. Goodwin, Chairman of the Committee on Hospital Insurance Policies. No further progress has been made on this subject but the Committee is continuing its work.

Mr. Sidney Davidson, Hospital Editor for the State Medical Journal, made a strong appeal to the membership for further support especially in the securing of advertising.

Doctor Albert Buck, Hospital Representative to the State Board of Examiners for Nurses, reported on the meeting stating that the nursing situation continued serious with a very definite shortage. Little progress has been made in the development of a program for institutional aides with two schools functioning at Manchester and New London. Some cooperation had been made with the State Department of Education. Following this report, the suggestion was advanced that it might be advisable to consider advertising hos-

pital employment other than nursing and to give consideration to planning for voluntary help this summer.

At this time Mr. Brough suggested that the Trustees give careful consideration to the continuation of advertising in the JOURNAL after this year due to the increasing difficulty in securing advertisements.

Voted:

That the Trustees give consideration to the wisdom of continuing present arrangements with the STATE MEDICAL SOCIETY JOURNAL for the coming year.

A communication and invitation was read from the Hospital Association of New York State inviting our members to attend their Spring convention, which, however, conflicted with the dates of our own Association.

The suggestion was also advanced that it might be helpful for our Association to select a committee to confer with the Selective Service Boards on deferment of members of hospital personnel in the Draft.

Voted:

That a committee be appointed to confer with Selective Service Boards in regard to deferments of hospital personnel.

Doctor Allen called the attention of the delegates to the next meeting of the New England Assembly in March, 1942, and requested that suggestions be advanced for the development of the program for this meeting.

The President then stated that the meeting was open for further discussion on any hospital subject.

Miss Griffin presented for discussion the question of hospitals giving discounts to the staff and the problem of uniform discount rates to the Professional Staff. Many members joined in the discussion and presented a varied number of suggestions as to the manner in which their respective organizations met this problem.

The problem of handling dependents of draftees needing hospitalization was discussed. Several members advanced the information that in their respective localities the Red Cross provided funds to take care of such cases when no other means were available.

The lack of time prevented further discussion in the Open Forum.

Voted:

To adjourn at 5:00 P. M.

Attest:

William B. Sweeney, Secretary.

BOARD OF TRUSTEES REPORT

Summary of Meetings

To the members of the Hospital Association:

Since our last report at the Fall convention in New London, November 22, 1940, your Board of Trustees have had five meetings. This report summarizes the activities.

In January the Board requested consideration by the State Liquor Commission towards a simple means of withdrawing nontax alcohol purchased outside the State. Favorable action was received and all hospitals were advised directly from the office of the Commissioner.

The Trustees in combined joint action with the State

Medical Society requested deferment for internes before a local Draft Board including appointments for the year 1941-42. Representatives of our Board participated in the meeting for the joint Defense Council. This Committee has attempted to develop a summary of membership resources in this respect. Certain areas in the State have well developed local plans and the Governor has recently appointed a State Defense Council to coördinate all activities. The State Hospital Association, however, is without representation on this very important commission. The Trustees of the hospitals in eastern Connecticut have formed a council and communication in our files stating their desire to coöperate with the Trustees of the State Association in every manner.

The Connecticut Board extended an invitation to their special legislative group to become members of the Committee on Public Relations which was accepted and a general invitation was extended to all the Trustees to join the State Association personal memberships.

In conjunction with the development of Trustees' interest in Association problems, your Secretary has from time to time urged the filing of lists of Trustees of our member hospitals with the Board with little success. Up to date, only five member hospitals have complied. The New England Assembly is attempting to perfect a list for all member institutions and it is impossible to coöperate with their program until our hospital superintendents give this matter further consideration.

Due to a complication in dates, the President and Secretary of your Board were unable to attend the midwinter conference of the State Association held at Chicago in February. A detailed report of this meeting is in our files. Mr. James Hamilton acted as alternate.

Your Board through newspaper items, a circular letter and direct telephone calls advised all members pertaining to the recent release of Sulfathiazole which was wrongly labeled.

The Board and our Association in general are deeply indebted to the splendid work of Doctor Geeter of New Britain and his Compensation Committee in their representation at the many conferences on the proposal submitted by the Compensation Commissioner and the insurance carriers. Doctor Geeter has been in constant contact with the Trustees and the Board feels that the membership today will follow with interest the detailed report of the program of this committee.

Our President, Doctor Wilmar Allen, was selected by the Trustees as the official delegate of our Association to the State Medical Society.

At today's meeting, Mr. Bartine, of the Council on Government Relations, will summarize the various legislative

bills that are receiving the attention of his Committee. Much credit for elimination of much undesirable legislation in the hospital field is due to the splendid work of Mr. Bartine ably assisted by our legal advisor, Judge Thomas, and the Council on Government Relations.

One of the recent Board meetings gave considerable time to a review of the suggested amendment to House Bill #76. The details of this bill will be covered in Mr. Bartine's Committee's report.

The Board at this time expresses its appreciation for the coöperation received during the year from all of our subcommittees and from the membership in general.

The report of our finances will be given in detail at this meeting by our Treasurer and shows a favorable balance.

To our members we trust that you will derive inspiration and benefit from this day's program and return to your respective institutions and face the future which promises to be a period with many new problems in the hospital field.

Attest:

William B. Sweeney, Secretary.

Sex Education for the Young

I would further urge parents and teachers to start sex education not only with the technical vocabulary of anatomy and physiology but also with the slang and colloquial words of the street. The child can use his sex information for his own protection only if he knows what the other children mean when they use the vocabulary of the street.

The parent and educator must see to it that sex information is not fragmentary and confusing.

I believe that sex education should be given by parents but also, and better still, by skilled educators in the class room of the school. Perhaps in a generation we can have a race of parents who know how to teach sex but I believe we would be safer if we taught sex now in school as we do all other fields of knowledge through teachers who are trained to teach.

*From paper by Leslie B. Hohman, M.D.,
presented at Seventh Conference on
Education and the Exceptional Child.*

SHOE FITS; PUT IT ON! — For the first time there is a shoe especially designed to provide a practical and comfortable covering for swollen, tender, or bandaged feet. "Mollo-pedic" shoes are easily adapted to various sizes of plaster casts or bandages on either foot. They afford proper support, yet are soft and flexible. A real pleasure to the patient, "Mollo-pedic" shoes truly protect. \$1.50 at the Professional Equipment Company in New Haven.

MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic

GEORGE M. SMITH, M.D., State Chairman, 258 Church Street, New Haven, Conn.

Connecticut Physicians Ordered to Active Duty (As of June 14)

John H. Browe, Hartford
 Sidney H. Burness, West Hartford
 *Edward P. Case, West Hartford
 Lewis Chester, New Britain
 Stanley H. Durlacher, New Haven
 Alphonse Gencarelli, Hartford
 Thomas L. Gingold, New Haven
 William P. Goergen, Danbury
 William Goodrich, Bridgeport
 *Howard R. Hansell, Sharon
 Thomas F. Hershey, Hamden
 William W. Josephs, New Haven
 *William B. Koufman, New Haven
 Robert M. Levin, Hartford
 *Henry R. Lewis, Wethersfield
 *Samuel D. Lewis, Hartford
 Jacob Mellion, New Britain
 Philip G. Merriam, New Britain
 *Joseph S. Riccio, Hamden
 *Lewis Thorne, New Haven
 Arthur S. Tucker, New Haven
 *Sidney Vernon, Willimantic
 *Robert Walker, Cornwall
 *Members Connecticut State Medical Society

The names and addresses of officers in the Medical Corps of the Naval Reserve ordered to active duty are no longer announced.

Changes in Selective Service Organization Board 25C

Harold T. Oesau, Stratford, resigned.
 Samuel H. Levy, Stratford, added as alternate examiner.
 Sidney L. Penner, Stratford, added as alternate examiner.

Experimental Induction Plan

The State of Pennsylvania has been selected as a testing ground for an experimental "waiting period"

induction plan, devised to simplify the process of inducting recruits in the Selective Service. For a month men will report to eight Army induction stations for final physical examinations. Those who pass will be allowed to return home subject to recall within ten to thirty days. Those rejected by the physical examination will return to a permanent civilian status. Previously men were inducted into service immediately after passing the final physical examination.

The Pennsylvania plan if successful will be applied throughout the country. It is designed to give the registrant more time to adjust his affairs. In the beginning the waiting period will be ten or twelve days but will gradually be increased up to nearly thirty days. It cannot exceed that length of time because the Army requires reexamination after thirty days. The plan also offers advantages for the man who is not physically fit for it gives him an opportunity to continue in his present status without interruption.

Psychiatric Suggestions Concerning Selection for Military Service

EUGEN KAHN, M.D., *New Haven*

The present war has been called a war of nerves since quite some time, and, according to all the information we have about it, this designation is only too correct. Hence it is not astonishing that the demands on the medical profession and in it on the psychiatrist are considerable and probably will increase. It should be understood that this war has already become a war of nerves also for nations and countries that are not or not yet actively involved in it, and that even in these countries it has clearly become a task of tremendous importance to control the nerves or, as one might better say, to keep up the morale. Needless to emphasize, in this task the medical profession is to play a role of some importance.

If we realize what the war means for the population at large, we cannot fail to realize what it must

mean for those individuals who are most actively involved in it, that is for the military. More than ever before it is a problem to find the best ways and means carefully to select men for military service, which of course includes the problem of disqualifying those whose presence in the army or navy might be undesirable or dangerous or even detrimental. To do this it is necessary first to get an idea of what kind of men are wanted for military service. All the remarks we are going to make about this, as about all other questions, we make from the point of view of the psychiatrist who is a physician, as all other physicians are, but who is not called upon to judge or to decide what particular physical shortcomings or defects lead to the exclusion of men from military service. Here we may mention that organic neurological conditions are likely to be picked up in the routine physical examination.

Rather generally formulated, what is wanted are young and healthy people who are well adjusted in their actual position or situation, and who appear to be pliable enough to adjust to the very particular situations in the military services. That is, people with military aptitude which, of course, is something profoundly different from the militaristic attitude. We daresay that the great majority of experienced physicians are or will be able to come to positive decisions on the background of this rather broad outline. The real difficulties arise in the doubtful cases where the realization of what is not wanted may be of some help: not wanted are sick and sickly and weak people who are poorly adjusted in their present situation or position, and such ones who are or threaten to be troublemakers. It is in such cases that one may assume, without any psychiatric overbearance, the non-psychiatric physician will find it difficult or impossible to come to a decision of his own. It is in such cases, too, in which the non-psychiatric physician not only should feel free, but should be encouraged to refer the examinee to the psychiatrist.

Psychiatric diagnoses are not always easy; it often takes much time to come to a somewhat safe psychiatric diagnosis, and in many cases that do not click with the textbook descriptions it is impossible to formulate a diagnostic opinion in 15 or 30 minutes. But there are certain features which can be observed even within a very short time, and which can be used as hints for a more specified exploration or examination. A few of these features we may enumerate: excitability, anxiety, tenseness, irascibility,

high grade sensitivity, suspiciousness, tendency to over-emphasizing certain events in the past life, especially over-emphasis of really or allegedly experienced sickness, i. e. tendency to hypochondriacal complaints, stressing of disappointments experienced, complaints about all kinds and numbers of difficulties in daily life, tendency to blame and to accuse other people for failures, feminine or girlish bearing and manner of speaking, and so on. It is obvious that some of these features will come out quite spontaneously in the behavior and in the utterances of the examinees, whereas others can only be brought out through questioning.

It goes without saying that material concerning the past life of the examinee should be secured wherever possible; this can be partly done by direct questioning. Almost as important, however, is it to get school and work, police and court records, and records of social agencies. The utilization of school records alone will make possible the sending home of a goodly number of feeble-minded without giving them any prolonged examination. There always, of course, will be some feeble-minded people coming for examinations whose more or less clumsy or stupid behavior and whose poor answers to even simple questions will put the examining physicians quickly on the right track. The other records mentioned will help to recognize numerous people whose presence in the military services would be definitely undesirable, as for instance certain "black sheep." We are emphatically of the opinion that the military services should not be considered as playgrounds for black sheep and criminals.

In most instances it appears to be worthwhile to find out the examinee's attitude towards the possibility of being qualified for military service. Often enough the attitude of the young people is a perfectly natural one: although not being enthusiastic, they take it for granted that they have to do their duty for their country and are willing to do it without any fuss. There are some, though, who show a most pointed aversion towards any sort of military service, and consider the mere possibility of being drafted as an interruption of their personal lives with their privileges which, in their opinion, nobody is justified to wish upon them. Such an attitude by no means per se disqualifies an examinee; only if it grows on the ground of an ill-adjusted person might it help to lead to considerations on which finally a disqualifying decision may be based. On the other side, there are a few youngsters who show such an

unbounded over-enthusiasm to "join" that this very over-enthusiasm appears to be a manifestation of a definitely ill-poised person.

Overt conditions of actual mental disorder will, in most instances, betray themselves in well-known psychopathological symptoms as depression, slowness, defects of memory and judgment, exaltation, grandiosity, rigidity and stiffness in posture and talk, quarrelsomeness and belligerency. Less alarming but in no way negligible symptoms are outspoken vasomotor instability, stuttering, grimacing, facial and other tics and other abrupt or unusual movements, sloppiness in dress and lack of bodily cleanliness or over-meticulousness in dress and physical care. They may make the way clear even if no label diagnosis is made.

The question of malingering should not be forgotten. We feel that malingering does not play such a great role as it was once supposed, and we are furthermore of the opinion that the majority of the malingerers are poorly adjusted people anyway whose value for military service is very doubtful.

Concerning the question of the conscientious objectors, we only want to say that this is not per se a psychiatric problem, although once in a while the psychiatrist may be asked if the objector is really a conscientious objector or not.

The use of the psychiatric expert naturally depends on the local situation. In some places more psychiatrists are available and a very fortunate coöperation between the general examiners and the psychiatrists develops from the beginning. In other places there is a dearth of psychiatrists, and there are also places where the getting together of the general examiners and the psychiatrists does not seem to develop under lucky stars. We feel sure that adjustments can be made, and that with some mutual understanding the desirable coöperation can be brought about to the satisfaction of all examiners so that a most gratifying functioning of the boards is attained. The general examiner should be mindful of the fact that he does not work *for* but *with* the psychiatrist.

These short and sketchy remarks we take the liberty to address to all our colleagues who see draftees in first examinations. The situation is changed to some degree in the induction boards and later in the training camps. It is impossible, even with the help of a psychiatric expert, to find out every individual in the first examination whose disqualification would be indicated or desirable. This is easy to understand as it takes us weeks and months

once in a while in our psychiatric wards to come to a satisfactory diagnostic evaluation of a patient. There is no doubt, however, that the main business of separating the wheat from the chaff can be done and is done in the first examinations.

War Medicine — May 1941

The third number of *War Medicine* appearing in May contains much of interest to physicians. Two important contributions aimed at solving the problems of safely collecting, storing and transporting blood plasma and the drying of blood plasma are reported in this issue. There are several articles dealing with psychiatric phases of the present defense program. In one of these Doctor Elliott C. Cutler, professor of surgery at the Harvard Medical School, reminds his readers that modern warfare is no longer a combat of power only, but a combat in which brains may turn the tide to victory.

The essence of advice contained in the nine papers which compose the symposium is that adequate personal histories of all selectees, together with careful observations of the selectee by the examining physicians of local Selective Service boards, are the only means by which it can be expected that any success can be attained in keeping out of the army those men whose mental make up is such as to make them undesirable soldiers. It is pointed out in several of the articles that not only must the selectees be considered from the viewpoint of their ability to effectively serve as soldiers for one year of active training but also that these men will go into the reserve corps for ten years following the one year of training and that their capacity to remain efficient soldiers during that period of time must be taken into consideration when they are inducted.

New York City Selective Service Results

A larger proportion of the men in the age range 18 through 25 were found physically fit for military service than in age groups above that level, according to a report made by Colonel Samuel J. Kopetzky, Chief of the Medical Division, New York City Selective Service, submitted on May 31. The report is based on a statistical study of the medical reports of 82,565 registrants examined under the Selective Service System. Of the 82,565 men whose medical reports were studied, 37,329, or 45.21 per cent, were in the age group 18 through 25. Of them, 21,897 were accepted for full military service and inducted into the Army, while 8,373 were classified as I-B, and 7,059 were disqualified for any service.

THE LEGISLATURE

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

BERKLEY M. PARMELEE
Bridgeport

D. C. Y. MOORE
S. Manchester

SANFORD H. WADHAMIS
Torrington

JOSEPH A. BEAUCHEMIN
Middletown

GEORGE BLUMER
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EDMUND L. DOUGLASS
Groton

RALPH B. THAYER
Somers

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Danielson

JAMES R. MILLER
A.M.A. Delegate

JAMES DOUGLAS GOLD, President

CREIGHTON BARKER, *Executive Secretary*

THE 1941 GENERAL ASSEMBLY

The late, and probably not lamented, General Assembly of 1941 finally adjourned, as required by the statutes, in the late evening of June 4. Experienced legislative observers noted throughout the session that the activities of the Assembly were often confused and uncertain and never predictable. For the first four months there was so much delay and dallying that it resulted in the passing or rejection of legislation during the last hectic days without proper consideration. With the removal of the dual job ban the question of patronage concerned more people than the enactment of sound and helpful legislation.

There were an unusual number of bills having to do with welfare and medical subjects.

APPROPRIATIONS

The spending from the State general fund was unequaled in history. The Governor recommended general fund expenditure totaling \$60,826,439. The Assembly added nearly four million dollars more than had been recommended by the Governor for a total budget of \$64,850,567, an all time high.

BIRTH CONTROL

A substitute was introduced for the original birth control bills that had been introduced in the House and Senate. The Committee on Public Health and Safety brought in a favorable report and the bill was rejected by the Senate and failed of enactment.

CANCER

The measure appropriating \$25,000 a year for two years to the Health Department to further the work of the Bureau of Cancer Research which was supported by the Society was enacted.

COMMITMENT OF THE INSANE

The several measures introduced to revise the statutes having to do with the commitment of the insane, drug addicts, and dipsomaniacs failed of enactment.

CONSTITUTIONAL AMENDMENTS

A constitutional amendment providing a four year term instead of a two year term for the Governor and an annual rather than a biennial session of the Assembly was started on its long way to adoption.

DEPARTMENT AND COUNCIL ON MENTAL HEALTH

The two bills that would have established a Department or a Council on Mental Health which

would have coördinated the administration of the State institutions for the care of the insane and the mentally deficient failed of enactment.

DEPENDENT CHILDREN

New legislation will bring to the State \$1,000,000 of additional Federal funds which will cut the cost of child welfare to towns by half a million dollars and increase the charge on the State by a similar amount. A much larger number of dependent children will be eligible for benefits.

HEALTH INSURANCE

A measure that would have authorized a study of the availability of medical care in the State especially among persons of low income was introduced as a substitute for the Bingham health insurance bill. The study would also have included the care of the chronically sick which was covered in another bill. The substitute bill passed the Senate but was not acted upon in the House.

INDUSTRIAL HEALTH

The several bills that would have transferred, as a whole or in part, the activities and functions of the Bureau of Occupational Diseases from the Health Department to the Labor Department, failed of enactment.

MEDICAL PRACTICE

The revisions of the Medical Practice Acts introduced by the Connecticut Medical Examining Board were enacted into law except the provision requiring United States citizenship for eligibility for examination. Senator Cooney of Hartford introduced an

amendment removing the citizenship requirement and it prevailed. Otherwise the amendments as introduced by the Connecticut Medical Examining Board and supported by the Society were passed except for minor changes in phraseology.

OSTEOPATHY

The bill that would have extended to osteopaths the privilege of prescribing a large classification of drugs was unfavorably reported by the Committee on Public Health and Safety. A substitute was introduced by its proponents that would have allowed the privilege of prescribing these drugs after an osteopath had established his competence before a board consisting of the Connecticut Medical Examining Board and a Board of Osteopathic Examination received substantial consideration and support in the Senate under the guidance of Senator Baldwin of Westport. In the first vote on the measure the result was 11-10 in favor. Senator Downes of Norwich, the President pro tem of the Senate, was in the Chair and exercised the privilege of casting his own vote which was against, with a resulting tie. Since a majority had not been obtained it was ruled that the bill was rejected. Senator Baldwin requested the privilege of reconsideration in a subsequent session which was granted by Senator Downes. On the next day Senator Bingham moved a reconsideration and the reconsideration was lost 15-14. Another attempt at reconsideration was made by Senator Baldwin during the morning session of the final day, it did not again come to a vote and the measure failed of enactment.

BRIEF FILED BY THE SOCIETY IN OPPOSITION TO OSTEOPATHY BILL

On May 16 immediately following the introduction of the substitute for S. B. 519—An Act Concerning Osteopathy—the Society filed this opposing brief with all members of the Senate and House Committees on Public Health and Safety.

The Connecticut State Medical Society, through its Committee on Public Policy and Legislation, wishes to register its opposition to the substitute for S. B. 519—An Act Concerning Osteopathy. The physicians of Connecticut base their objections to the bill on the following:

1. A measure of such importance to the health and medical care of our people should not be hurriedly considered and hastily written into the law. It is our opinion that there is not sufficient time before the adjournment of the General Assembly to give this bill the careful and detailed consideration that it requires.

PAYMENTS TO HOSPITALS

The bill that would equalize the payment to hospitals by the State for the care of State cases was enacted. It requires the State to make sufficient payments at the rate of \$5 a day so that State aided general hospitals will incur no loss for the care of State patients.

PHYSIOTHERAPY

A Board of Examination and Licensing of Physiotherapeutic technicians was established. The measure providing this Board was introduced by the members of the Section on Physiotherapy of the Society and was supported by the Society. The new law requires The Connecticut State Medical Society to nominate physicians from whom the Governor shall appoint a Board of five who shall examine and make regulations for the licensing of physiotherapy technicians.

PRENATAL WASSERMANN

The bill introduced by the Committee on Public Health of the Society that requires a physician to cause a serological test for syphilis to be made upon pregnant women within thirty days of the first consultation was passed.

SOCIAL SERVICE INDEX

The sum of \$12,820 was appropriated to commence the compilation of a State Social Service Index.

TRAINED ATTENDANTS CERTIFICATES

The time for obtaining Trained Attendant certificates under waiver was extended to May 1, 1943. The previous period of waiver had been July, 1940.

2. One of the fundamental objections in the bill as originally drawn still remains. The amendment provides that osteopaths, after satisfying certain qualifications, "shall have the right to administer and prescribe anesthetics, antiseptics, sedatives and narcotics and biological products . . ." As previously pointed out simply naming all these classes of drugs does not state what they are nor what usage the bill comprehends. It does not state what anesthetics are and what ones can be used; or antiseptics or sedatives or narcotics. Neither does it provide for any authority to determine what drugs and remedies are included in these classifications. In this

connection the attention of the Committee is directed to a present controversy in the State of New York, where a similar measure was passed by the Assembly of 1940. Under the New York law osteopaths are now contending that through the privilege to use antiseptics they have the right to use the dangerous compounds of arsenic that are indicated in the treatment of syphilis. These drugs are injected into the veins of patients and their use should only be undertaken by one who is experienced and skilled. The Board of Regents in the State of New York has said that osteopaths may not use these compounds of arsenic and the contention now borders upon a court injunction. The same question might be raised with respect to biologicals. The people of the State have a right to know whether this law would give osteopaths the privilege to do the simple scratching of the skin for a Schick test in diphtheria or whether it means the introduction of antimeningococcus serum into the spine. The bill is silent as to who shall determine these things and indeed, it makes no provision for any determination.

3. The bill as amended says that an osteopath may be given certain privileges when he has satisfied a board "that he has received sufficient instruction and training" and among these privileges is the right to perform "such diagnostic procedures as are taught in approved schools of osteopathy." Under the present circumstances it would be a practical impossibility to impartially determine whether an osteopath had "received sufficient instruction and training in such diagnostic procedures as are taught in approved schools of osteopathy" unless the examining board was given the opportunity to visit the schools of osteopathy and make a careful scrutiny of their course of study. Except for the perfunctory statements in the catalogs of schools of osteopathy there is no information available concerning the quality and extent of instruction given. Schools of osteopathy are not inspected by the Council on Medical Education, and except for hearsay evidence there is no information concerning their courses of study. In this connection the attention of the Committee is drawn to a decision filed on May 2, 1941, in the District Court of the State of Nebraska, *STATE EX REL JOHNSON*.

"5. The practice of osteopathy consists of a system of manipulation of the limbs and body of the patient with the hands by kneading, rubbing or

pressing upon the parts of the body without the aid of medicine or operative surgery.

"6. A statute granting a licensed osteopath the right to practice osteopathy in all of its branches as taught in recognized osteopathic colleges, does not authorize such licensee to practice outside the recognized fields of osteopathy, even if subjects outside such fields are taught in such colleges."

4. The granting of the privileges stated in the amended bill constitute a large part of the practice of medicine, exclusive of surgery. It would be a nice decision as to whether an osteopath using all of the classifications of drugs included in the amendment, and the diagnostic procedures, was not actually practicing medicine, exclusive of surgery. There is already provision in existing statutes—Section 2754, 1930—for a registered osteopathic physician to obtain a license to practice medicine by an examination given by the Connecticut Medical Examining Board and it is not clear why this function should be duplicated by the now proposed amendment to the Section which provides another method by which an osteopath may obtain a license to practice medicine in a large part. The addition of three osteopaths, who constitute the said Board of Osteopathic Registration and Examination, to the Connecticut Medical Examining Board for the purpose of examining osteopaths has little to recommend it. The Connecticut Medical Examining Board has been considered competent to pass upon the medical qualifications of physicians for fifty years and it is not clear why that Board should require the assistance of three osteopaths when passing upon the medical qualifications of graduates of schools of osteopathy.

5. As previously pointed out there is no public need for the extension of these privileges. Connecticut is well supplied with physicians and the contribution to the public good and welfare that would be made by extending the medical privileges of eighty osteopaths would be infinitesimal. The measure continues to be a proposal for the economic advantage of this small group of osteopathic practitioners.

In addition to these objections we wish to point out that the proposed increase from \$15.00 to \$25.00 in the fee to be paid by osteopaths who appear for examination before the Connecticut Medical Examining Board is a voluntary proposal on the part of the proponents of this amended bill and has not been sought by the Connecticut Medical Examining Board.

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

CLIFFORD KUH, M.D., Chairman, New Haven

JAMES J. DONOHUE, M.D. Norwich	MARTIN I. HALL, M.D. Bristol	JOSEPH A. LAPALME, M.D. Putnam	PAUL W. VESTAL, M.D. New Haven
COLE B. GIBSON, M.D. Meriden	EMERSON S. HILL, M.D. Torrington	EUGENE C. MESCHTER, M.D. Stamford	BENEDICT N. WHIPPLE, M.D. Bristol
NORMAN E. GISSLER, M.D. Middletown	ROBERT P. KNAPP, M.D. South Manchester	ELLIOTT H. METCALF, M.D. Rockville	CHARLES F. YEAGER, M.D. Bridgeport
ALBERT S. GRAY, M.D. Hartford	ARTHUR B. LANDRY, M.D. Hartford	RICHARD O'B. SHEA, M.D. Bridgeport	

Pan-American Industrial Health

It is with considerable interest one reads that the next annual meeting of the American Medical Association will take on a Pan-American character. Recently the Pan-American League Against Cancer was organized to carry on the Western hemisphere activities of the one-time International Union Against Cancer, which has become inactive because of the war. Pan-American medicine is on the way.

Over a year ago at the dinner meeting of the Second Annual Congress on Industrial Health, held in Chicago on January 15, 1940, the proposal for the extension of an industrial health program throughout the Americas was voiced by Doctor Clifford Kuh, Chairman of the Committee on Industrial Health, Connecticut State Medical Society, who represented the Society at the meeting.

After stressing the economic, social and cultural values to be derived therefrom, it was then urged that the Congress on Industrial Health foster a program for the dissemination of knowledge on industrial medical service throughout the twenty-one American nations. "There would result therefrom a newer significance and greater regard for industrial health activities in our own country. But above all it must be remembered that any steps which fortify the place of the Americas and particularly the United States in world affairs will tend to assure them the position of leadership which it is hoped they may be called upon to assume in the task of negotiating for a permanent world peace."

Recently Doctor Carl M. Peterson, Secretary, Council on Industrial Health American Medical Association, wrote Doctor Kuh, as follows: "You will be pleased to know that the House of Delegates has indicated that the next Annual Session of the American Medical Association at Atlantic City will

be in the nature of a Pan-American Medical Congress. So your recommendations of a year and a half ago at the Congress, and I presume elsewhere, must have fallen on appreciative ears."

Congress Studies Industrial Program

Connecticut is one of the first states to have its handling of problems arising out of defense production evaluated by "The Select Committee to Investigate Migratory Labor" under the chairmanship of Hon. John H. Tolan, Californian member of the House of Representatives. Hearings were held in Hartford on June 24 and 25, John W. Nickerson, General Superintendent, Cheney Brothers, Manchester, acting as moderator for witnesses presented by the Manufacturers Association of Connecticut.

For the benefit of the investigating committee the comprehensive, state-wide activities of nearly twenty federal, state and local agencies, organizations and committees in tackling Connecticut's defense problems were described in a 150-page report, prepared by the Manufacturers Association. Forty pages were devoted to the work of the Joint Committee on Industrial Health of the Manufacturers Association and the Connecticut State Medical Society and to the program of the Bureau of Occupational Diseases of the State Department of Health.

The report dynamically portrays democracy in action, practically the entire endeavor representing "the prodigious labors of busy men, who gave enthusiastically hundred of hours" to consideration of the following subjects: Housing, industrial health, upgrading and training of workers, intrastate and interstate migratory labor, use of available labor reserves, employment problems involving race, nationality and physical handicaps, and the farming out of defense production.

The brochure on "Conservation of Man Power,"

reproduced in the June issue of the Connecticut State Medical Journal, was embodied *in toto* in the second section of the report.

Just as Connecticut was one of the first states to appreciate the need for developing an effective employee-training-for-defense program, so it has been equally quick to realize the multiplicity of problems in the field of industrial health caused by the speeding up of defense production.

Mr. Nickerson, who is also Chairman of the Committee on Emergency Employment Problems of the Manufacturers Association, in his introductory statement in the report comments, as follows: "The manufacturers of Connecticut are fortunate in that, to the best of our knowledge, Connecticut is the first state to initiate an effective program on industrial health in which the State Department of Health, the State Medical Society and the Manufacturers Association of Connecticut are working in close coöperation."

Plans for Small Plants

Two Connecticut communities, Middletown and New Haven, have been studying the question of rendering effective medical service to small industries.

Last April the Middletown District Nurse Association called an informal meeting for discussion of the matter, to which were invited representatives of the local Chamber of Commerce, Committee on Industrial Health of the Connecticut State Medical Society, local industries and the Bureau of Occupational Diseases of the State Department of Health, as well as the local health officer.

The most important conclusion reached by the group was that, since the industrial nurse cannot function unless she is under the supervision of a physician and, since most of the small industrial plants do not have the services of a physician, a serious effort should be made to acquaint industrial concerns with the desirability of obtaining medical service first of all through the employment of physicians at least on a part time basis. This plan would facilitate and foster industrial nursing service.

By way of following the interest shown at the meeting the executive secretary of the Middletown Chamber of Commerce has been personally attempting to interest small, local plants in an industrial medical program.

In New Haven, Doctors John R. Paul and Louis G. Welt of the Department of Preventive Medicine

of the Yale University School of Medicine have also been engaged in developing a plan for servicing small industrial establishments. The plan as originally conceived and presented at a special meeting of the New Haven Medical Association was not approved, but a compromise proposal is now in process of formulation.

At a recent meeting of the New Haven Medical Association a motion was approved that a fact finding committee be appointed to study all plans for rendering medical service to small plants, such as those which have been proposed or tried in Berkeley, California, Philadelphia and Toronto. The committee appointed for this purpose consists of Doctors A. Lewis Shure, Chairman; Vincent Grillo, Secretary; John Bodie, Samuel Climo and Robert Tracy.

Address Emphasizes Nutrition

At a joint meeting of the New Haven and Hamden Leagues of Women Voters held at the Woman's College, New Haven, on June 11, 1941, to discuss "the battle of production" an opportunity was afforded to emphasize the importance of nutrition in holding the front line.

Doctor Clifford Kuh, Chairman of the Committee on Industrial Health of the Connecticut State Medical Society in a talk on "Health and Defense" urged local coöperation with federal and state efforts to improve the nutrition of industrial workers.

The program advocated by the recent National Nutrition Conference was reviewed, and also that of the newly created Connecticut State Nutrition Defense Committee. Coöperation of industry was advocated in determining particularly whether the nutrition of the over time worker and the man on the night shift is adequate. Investigation was suggested, in accordance with the Nutrition Committee's recommendations, to determine whether—

(a) The present lunch room services for workers adequately meet their needs as to "hidden hunger" (lack of protective foods) as well as "hollow hunger" (lack of calories).

(b) Whether supplementary mid-meal food for the workers would make for greater health and efficiency.

(c) Whether local lunch facilities in the area of the plant meet the required standards for adequate food.

(d) Whether information about food is made available to workers through educational methods

within the plant or to their families by means of industrial nurses and other personnel.

The speaker advised that a local committee be formed, whose representatives would go into a plant and discuss diets with a carefully selected "sample" of workers. The committee might make recommendations as to effective educational material and how to distribute it.

The Food Selection Score Card, recently printed for distribution by the Connecticut State Department of Health, was referred to as illustrative of the simple, down-to-brass-tacks type of educational literature the worker needs. The card permits a daily evaluation of one's diet on the basis of 100 points; 20 points being allowed an adult for drinking two glasses of milk, 35 points for including fruit and vegetables, and so on.

Section Re-elects Officers

At the annual meeting of the Section on Industrial Health, held on May 21, 1941, at the Hotel Stratfield in conjunction with the annual meeting of the Connecticut State Medical Society, both Chairman Eugene F. Meschter and Secretary Edward G. Hurlburt were re-elected to office by unanimous vote of the members present.

The speaker on the occasion was Doctor Anthony J. Lanza of the Metropolitan Life Insurance Company, whose talk on "Health Plans for Small Industries" was discussed by Doctors Paul Brown, Clifford Kuh, Arthur Landry, Joseph Linde, Crit Pharris, Richard Shea and Charles Yeager.

Seven-Point Research Program

The Joint Committee on Industrial Health of the Manufacturers Association of Connecticut and the Connecticut State Medical Society at one of its early meetings recommended the extension of research activities as a means of improving industrial medical practice in Connecticut. Recognizing the role that the university of the future will play in conserving industrial man power, it suggested that such research be engaged in "by industry, the medical profession and the university."

Among the various conditions deserving further study were mentioned the following:

1. Improved methods of diagnosing, classifying, and treating occupational diseases and injuries.
2. Methods of measuring and controlling new and unusual industrial health hazards.
3. The effect on the health and efficiency of employees of such factors as fatigue, emotional strain (especially that of war or defense preparations), social and economic problems, housing, etc.
4. The influence of types of work or of general plant conditions (lighting, ventilation, sanitation, etc.) upon the health of employees, notably upon the spread of respiratory and other communicable diseases.
5. The effect upon the mental and physical health of employees of employee relationships and the attitude and policies of management.
6. Elucidation of standards of physical and mental fitness for work (including aptitude tests) classified by job, with emphasis on rehabilitating and placing old or handicapped workers.
7. The effect on the health and efficiency of employees of a deficiency of one or more vitamins or other essential foodstuffs.

BRIDGEPORT APPROVES

(Continued from page 524)

made in some plan sponsored by the Medical society and its members in Fairfield county.

A commission, for the appointment of which the society was largely responsible, and headed by the "spark plug" of the medical profession in Connecticut, so far as its public relations go, Doctor Creighton Barker, has been studying methods and facilities in the hospitals and other institutions of the state of Connecticut, and has made many valuable recommendations. Its work continues.

As the state medical society comes to Bridgeport for its convention, for the first time in years, there is an actual shortage of doctors, not necessarily in any one community, but in the country generally, because of the additional demands of the army and navy. One local hospital, at least, is finding it difficult to enroll the desired number of internes for the coming term. Young men who are studying to become doctors, are to be deferred in the selective service for the army.

It is a "seller's" market for the men who have their service to sell, as physicians and surgeons, and it is well that it is so. But this picture is not in harmony with the gloomy anticipation of some of the medical men themselves, of the woes of "socialized medicine."

If the people are kept fully informed, the doctors need have no fear that, when the time ever comes to make an important decision on such a subject, they will not decide wisely.

But that is an event for some tomorrow; and it is today that the doctors are here. So, in busy Bridgeport, we say to the doctors of all Connecticut: Hi-ya, doc!

ANNUAL REPORTS

REPORT OF THE PRESIDENT CONNECTICUT STATE MEDICAL SOCIETY

Gentlemen of the House of Delegates:

In my brief message at the 1940 meeting of the Society, I made the following statement:

"With a full coöperative membership, a hard-working council, an efficient executive office, a first-class Journal, progressive committees, and a well-informed House of Delegates, the work before us should be done well and with pleasure." In the past year this has been achieved in the various departments of our organization. Careful reading of the Journal reveals a tremendous amount of work done by the Society, but the results of that work are not immediately manifest. Time will evaluate the degree of our success.

As you know, at the beginning of my term of office, I emphasized the importance of enrolling in the Society every qualified practitioner of medicine in the state. The result of the drive for members was not as gratifying as was anticipated. However, I am sure that the effort for increasing our membership will be continued. New Haven and Fairfield County Associations made the largest gains in new members this year, due in large part to the efforts of their respective presidents. I congratulate them and thank all others who have taken an active part in building up the Society membership.

Perhaps one of the most satisfying duties of your President is the tour of the County Associations during which the opportunity is given for discussing the many problems which confront us. It was my good fortune to be able to attend all of their fall and spring meetings at which was observed the finest feeling towards the parent organization. The meetings were, for the most part, well attended. The scientific programs were usually given by members of the Society, and here I should like to say that all presentations were exceptionally good. Most of the County Associations have been rewriting their Bylaws to conform with those of the State Society. All of which makes for smoother administration of our affairs.

It was my intention to attend at least one meeting of each committee of the Society, and I was able to attend the following:

1. Several meetings of the Committee on Medical Preparedness.
2. Four meetings of the Committee on Industrial Health.
3. Two meetings of the State Legislative Committee.
4. Three meetings of the Committee on Public Policy and Legislation.
5. Two meetings of the Committee to Study Prepaid Medical Service.
6. Two meetings of the State Tumor Committee.
7. One meeting of the Bylaws Committee.
8. One meeting of the Clinical Congress Committee.

9. One meeting of the sesquicentennial Celebration Planning Committee.

In addition to these, I attended the fall meeting of the House of Delegates, all but one of the Council Meetings, two hearings on legislative measures at the capitol—one on the Compulsory Health Insurance Bill, and one on the Osteopathic Bill. I also represented the Society at the Annual Meeting of the Pharmaceutical Association held in Groton in June. I presided at a meeting of the School Physicians held at the Hunt Memorial in Hartford, and attended a meeting of the First Aid Committee of the Connecticut Chamber of Commerce held at the Connecticut State University at Storrs. As your President, I had the pleasure of attending the testimonial dinner given Doctor George Blumer by his friends and pupils at the Taft Hotel in New Haven, and another dinner given for Doctor William F. Verdi by the Advertisers' Club of New Haven in recognition of his outstanding services to his community, and also attended a dinner of Region I of the American Academy of Pediatrics in New Haven, March 28.

As your President, I presided at the Mid-winter dinner of the State Medical Society held at the New Haven Lawn Club, at which Doctor Frank Lahey, President-elect of the American Medical Association, was the speaker. Lastly, your President represented the Connecticut State Medical Society at the Sesquicentennial meeting of the New Hampshire State Medical Society held in Manchester, N. H., on May 13th-14th.

As in 1917, members of the Society are responding to their country's call for medical services. Some already hold commissions. Many are serving on draft boards, and events indicate that most of us, in one way or another, will be connected with the medical defense program. The medical profession in the State of Connecticut will not be found wanting as the need develops.

The work of the Society is ever increasing; and when the State Legislature is in session, becomes very heavy, demanding much extra time of our Executive Secretary. I wish to thank Doctor Creighton Barker for his untiring devotion to his office and his generous efforts in helping make the work of my office more effective and less arduous. We all owe him a debt of gratitude.

In the discharge of my duties as your President, I have done my best to foster the interest of all; and if I have failed in some measure, I assure you it was not for lack of willingness or application. I have had a full year and one of the most enjoyable experiences of my life. Permit me to thank you from the bottom of my heart for the great honor you chose to bestow upon me and also to express my deep gratitude to the members of the Council and to the many members of the Committees who have borne with me in bringing the Society through another year.

Respectfully submitted,

Arthur B. Landry, M.D., President.

SUPPLEMENT TO THE ANNUAL REPORT OF THE PUBLIC HEALTH COMMITTEE

Since the annual report of the Public Health Committee was submitted for publication in the Journal, one meeting has been held on Thursday, May 8, 1941. The Committee listened to a report by Doctor Souther of the State Department of Health on the method of study of neonatal deaths which is to be conducted very shortly.

The entire list of obstetrical and pediatric consultants who have acted during the past year were reappointed for another year.

The Committee discussed the rise in the maternal mortality in Connecticut and felt that some of these deaths could be avoided, especially in the toxemia group, by more prenatal clinics. There are a number of hospitals in the state with a fairly large maternity service which offer no prenatal clinic. The Committee therefore approved a plan of increasing the number of prenatal clinics and suggested that the Chairman of this Committee write to the various hospitals urging the establishment of improved obstetrical service.

The Committee also approved a plan for a study of the facilities and practices on ward and private services at maternity hospitals. Previously, all the material collected was grouped under the particular hospital heading, but no attempt was made to separate the ward from the private cases. Heretofore it has been the custom for the obstetrical consultants to be called by the family physician to see a patient in the home before hospitalization. Emergencies arise whereby it is necessary that the patient be moved to the hospital immediately, and it is the feeling of this Committee that the consultation may take place after the patient has been admitted to the hospital.

The Committee also approved the appointment of a medical social worker who shall devote part time to pediatric and obstetrical program, the remainder of her time being confined to the crippled children's work.

During the past few years the Committee has attempted to stimulate postgraduate study in pediatrics and obstetrics. So far the various plans proposed apparently have not been acceptable to the various groups throughout the State. The Committee therefore suggested that a subcommittee be appointed to make a study of this problem and report back at a fall meeting. The Chairman appointed Doctor Musselman and Doctor Colwell of New Haven as a subcommittee.

The Committee also approved a plan for sending nurses to the Boston Lying-In Hospital where special two weeks courses will be given in the care of premature infants.

In the past five years a demonstration program of maternal care has been conducted in Windham County. It is felt now that this program should be moved to some other section of the state. The Committee therefore approved of a program to be conducted in the Naugatuck Valley and instructed Doctor Clifford to proceed with arrangements for this demonstration.

The evaluation of laboratories which has been conducted during the past year has been completed. The Committee approved a plan for the continuation of this study for another year, to determine if there is an improvement in certain laboratories not meeting requirements.

Considerable time has been given by this Committee in

the study of maternal and child health, and it is the feeling of several members of the Committee that other problems pertaining to public health should be discussed. These are to be submitted to the Chairman of the Committee and at an early meeting in the fall these subjects will be discussed. The Committee would appreciate any suggestions from the members of the State Society.

Respectfully submitted,

Joseph H. Howard, M.D., Chairman.

8A Blues

(Any similarity to any registrant in Board 8A is purely coincidental)

Boy, have we some physical wrecks,
From hammer toes to broken necks;
If they don't suffer from arthritis,
They're sure to have osteomyelitis;
If their eyes are qualified,
Their teeth are probably falsified.
This guy has some rare disease,
The other one's fat—it's called obese.
Here's one—has a finger missing,
One case of cold sores—too much kissing.
A strange case, next, concerned with germs
Sounds mighty important in medical terms.
One has something called thrombosis,
Another poor guy has halitosis.
This one coughs, they take an x-ray,
To find out if he'll live 'til next day.
Then there's one St. Vitus Dance case;
Acne marks another one's face.
One Form reads he can't be cured,
Why, he can't even be insured!
This one hardly seems alive,
I doubt if he'll see thirty-five.
The one we have with one ear off,
Had measles, mumps and whooping cough.
This man brags about his ills,
The next one's sick, so he takes pills
Who ever heard of scoliosis,
Or ring-worm called epidermiphytosis?
One looks alright, he's just too thin;
This one has a wooden limb.
At last we find a I-A lad,
From twenty exams—that's very bad.
His eyes and teeth and feet are sound,
In fact, he's O.K. all around.
He's qualified for general service,
Then his boss starts to get nervous.
He files Form 42, and then
Our troubles start all over again.
Hartford says—"Now, no despairs,
Get busy; send out more questionnaires."
We start right in again from scratch
Pick for exam another batch.
Then more Forms 42 we see,
We're sure got troubles, OH, Me! OH, ME!

Kitty Greenberg, Steno. Local
Board 8A, New Haven, Connecticut.

OUR NEIGHBORS

Maine

The office of the Maine Medical Association and the Journal of the Maine Medical Association, formerly located at 22 Arsenal Street, Portland, has been moved to the Congress Building, 142 High Street, Portland.

New York

This year for the first time a new and important session was added to the scientific program of the annual meeting of the Medical Society of the State of New York, a session on the history of Medicine in the State. The State of New York has played a notable part since colonial days in the history and development of the science and practice of medicine, both civil and military.

Vermont

Doctor George A. Elliott, assistant superintendent of the Connecticut State Hospital, Middletown, has been appointed superintendent of the Brattleboro Retreat, Brattleboro. He succeeds Doctor Horace G. Ripley who resigned.

NEWS

from County Associations

Hartford

Doctor Charles C. Wilson has just announced his resignation as director of health for the City Schools of Hartford, to accept a professorship at Teachers College, Columbia University. Aside from his work in the Hartford Schools, Doctor Wilson has been active in national and state health organizations. He is President of the Hartford Tuberculosis Society and Vice-president of the Connecticut Tuberculosis Association.

The annual meeting of the Interne Alumni Association of St. Francis Hospital was held at the Avon Country Club on Thursday, June 12. A banquet and entertainment were held in the evening, preceded in the afternoon by a soft-ball game, golf matches

and exhibitions of quoit throwing. The winners in the latter contest were Doctors Thomas Murphy and James Cullen, the runners up being Doctors Richard Dunne and Thomas Welch. Doctor Louis Hastings won the golf match. About six door prizes were awarded.

Middlesex

Doctor Carl P. Wagner, physician in charge of Elmcrest Manor, announces that Doctor V. Gerard Ryan of Boston joined the staff at Elmcrest Manor as Associate Psychiatrist on June 15. Doctor Ryan is a graduate of Holy Cross College, served his internship at St. Francis Hospital in Hartford and later at Boston City Hospital where he did special work in the Neurological Unit. He then spent some time at Butler Hospital in Providence and Boston Psychopathic Hospital and for several years was associated with the Austen Riggs Foundation in Stockbridge, Massachusetts. Doctor Ryan recently has been resident physician at Baldpate, Inc., and Assistant in Psychiatry at Harvard Medical School.

New Haven

Doctor David R. Lyman of Wallingford represented the Connecticut Tuberculosis Association as Representative Director on the National Board at the 37th annual meeting of the National Tuberculosis Association at San Antonio, Texas.

Doctor Joseph I. Linde of New Haven was the official delegate to the same convention from the Connecticut Tuberculosis Commission.

Doctor Clifford Kuh of New Haven, Chairman of the Committee on Industrial Health of the State Medical Society, is the author of an article entitled "Employee Morale and the Industrial Health Program" which was published in the March-April number of Proceedings of the Life Extension Examiners.

New London

The New London City Medical Society held its regular monthly meeting at the Mohican Hotel, May 15. After a short business meeting Mr. Philip Plant of Waterford, gave a most interesting talk illustrated with colored motion pictures about his scientific expedition into Africa for the Museum of National History of New York. Mr. Plant brought back many valuable and rare specimens of animals which are on display at the museum in New York. His description of the preparations for his expedi-

tion, the high standards set up by the Museum in the collection and preparation of specimens, necessitating the employment of capable and experienced scientists, was most interesting and educational.

The New London County Medical Association held its regular monthly meeting at the Norwich Inn, June 5. Dinner was served to a large assembly of members and to the speakers at 7:00 P. M. The scientific meeting, Symposium on Low Back Pain, was conducted by five Hartford specialists. There was an unusually large attendance. The speakers were: George Gosselin—Neurologist, Bernard Spillane—Urologist, Hartwell Thompson—gynecologist, Sidney McPherson—Orthopedist, Claude Kelly—Surgeon. The presentation by the five speakers of this timely topic was well received. Doctor Daniel Sullivan, New London, spoke briefly on Medical Defense plans for this county.

Doctors Carl H. Wies and James P. Moran, who were recently called into active service as reserve officers, were tendered a dinner on May 14 at the Mohican Hotel, New London, and presented traveling cases by fellow members of the New London City Medical Society. Following the dinner an entertainment was enjoyed. Doctor Wies is a captain in the 11th Coast Artillery, stationed at Fort Wright, N. Y. Doctor Moran is a lieutenant in the U. S. Navy, M.C. (R), and is now on duty at the Submarine Base. Almost a hundred per cent attendance of the New London City Medical Society came to honor their two colleagues.

Doctor James Moran was married to Miss Grace McNamara of Poughkeepsie, N. Y., June 7. He has been detached from duty at the U. S. Submarine Base, New London, and ordered to sea duty on a U. S. cruiser.

Doctor Charles Krinsky of New London, was appointed associate consultant in Neurology at the State Hospital for Insane at Norwich.

Doctor John Hurlbut Buell, a graduate of McGill University, who was Resident in Surgery at Uncas-on-the-Thames from January 1, 1940, to January 3, 1941, has been commissioned a lieutenant in the U. S. Public Health Service. He is stationed at the Marine Hospital, Windmill Point, Detroit, Michigan, where he is a Resident Surgeon.

Assistant Superintendent Doctor Ronald Kettle, is acting Superintendent of the State Hospital for the Insane at Norwich while Doctor William A. Bryan is on vacation.

Doctor Vanderveer Carr of the Norwich State Hospital for the Insane was granted a leave of absence for a year on account of ill health.

Doctor John Raymor of Norwich has been appointed an associate examiner to Draft Board, No. 19.

Doctor Glen R. Urquhart of Uncas-on-the-Thames, recently attended the annual convention of the American College of Chest Surgeons in Toronto, Canada.

Doctor James Donohue of Norwich has returned home following a stay at the New Haven General Hospital. We are glad to announce that Doctor Donohue is doing well and it is hoped that he will be back in harness soon. Doctor Donohue is Compensation Commissioner for this district.

Doctor Seymour M. Faber, for the past year Assistant Physician at Uncas-on-the-Thames, has been granted leave of absence for a year to accept an internship at the Newton Hospital, Newton Lower Falls, Mass. He will return to Uncas-on-the-Thames on the completion of his internship.

Doctor Lee S. Senella, Interne at Uncas-on-the-Thames, has been appointed to an internship at the Newton Hospital, Newton Lower Falls, Mass., for a year starting July 1, 1941.

THE DOCTOR'S OFFICE

Dwight E. Wilson, M.D., announces the opening of his office for the practice of Diagnostic and Surgical Urology, 291 Whitney Avenue, New Haven. Office hours by appointment.

Rocco G. Lapenta, M.D., announces the opening of his office for the practice of General Medicine at 1307 Albany Avenue, Hartford. Office hours, 1 to 3 and 7 to 8 P. M.

Paul R. Johnson, M.D., announces the opening of his office at 678 Farmington Avenue, West Hartford, for the practice of Obstetrics and Gynecology. Office hours by appointment.

All medical students in Argentina in the future must undergo x-ray examination and tuberculin tests on the result of which their permission to study medicine depends. *Schweizer Med. Woch.*, June 22, 1940. Noted in *Tubercle*, January, 1941.

THE FORUM

The "why" an apparently normal person harbors virulent pathogenic organisms without harm is a tidbit of research that has intrigued the medical profession for generations. Many theories have been advanced to explain the trigger factor, but as yet none has proved to be more than a step toward the final solution. Those based on immunogenic and hereditary influences have stood the test of time and have been valuable in final application. Others predicated on symbiotic, pleomorphic or bacteriophagic factors are still in a highly argumentative phase. A third based on climatic and atmospheric pressure changes has had little encouragement. During the past year, two more approaches to the problem have appeared in the literature. One group of workers found that lack of a vitamin factor, labeled M, was responsible for an invasion by the Shiga strain of bacillary dysentery. This immediately opened up many possibilities since this M factor seems to be an essential amino acid. If this is so it strongly points to dietary faults as contributing elements. Another group of workers, coupling research in vitamin deficiency and hormone balance discovered that deficiency of one element of the adrenal cortex in combination with avitaminosis set up a vicious cycle of metabolic changes. This in turn setting the stage for a bacterial invasion. It is more than probable that the way out of the maze lies somewhere between these new theories.

Nothing sends a patient in search of a doctor quicker than acute, severe pain; and nothing creates as lasting an impression on the patient as prompt relief of that pain. Excluding the many conditions that require general sedation, local anesthesia offers the quickest and surest method of control. For some time now, it has been used with complete satisfaction in low back pain, fractures, ankle sprains and

in the bursas, especially those of the shoulder girdle. During the past few months we have tried it in two other annoying conditions, neither one of which has ever been reported in the literature. Heretofore we had relied on sedatives, local heat and diathermy in the treatment of acute torticollis—stiff neck—and the acute spasmodic myalgias such as the so-called charley horse. More often than not we would lose the patient to one of our 'opathic practitioners whose adjustment rather than the lapse of time element impresses the patient. It is equally true that hospitalization and application of proper suspension and traction will promptly relieve these conditions, but the disease does not justify the expense involved. Novocaine in 2% solution, with or without epinephrine, injected into the most painful part of the muscles involved works wonders. No particular technique is required and only the usual precautions are necessary, namely, asepsis and certainty that the needle has not entered a vein. Our own method is to raise a skin wheal over the area before inserting the longer needle. Through this wheal we inject several places in the muscle. Average total amount of solution used is 3 cc. distributed in ½ cc. amounts. After the treatment the patient moves the affected part without pain and is encouraged to continue active motion. In twelve cases we have not had to repeat an injection.

As time goes on more uses for solutions of tannic acid are being discovered. Papers have already appeared describing its efficiency in intertrigo and chafing in general, poison ivy and other forms of acute dermatitis. To these we would like to add that it is equally as efficient in the local treatment of herpes zoster. If we could recognize it before the appearance of blisters, intravenous injections of potassium iodide would suffice to abort it. However, when the local reaction appears we debride the area and apply a fresh 5% solution of tannic acid followed by 10% silver nitrate. The tan produced relieves the local pain and minimizes scarring.

T. P. R., M.D.

WEATHER MAKER: — There is now available a perfected and easily installed air conditioner which will really cool the doctor's office at a very nominal cost. Simply plug it in and it will cool, filter, dehumidify, change, and circulate the air. The Professional Equipment Company of New Haven is Connecticut's distributor to doctors.

(SEE PAGE 2)

OBITUARIES

Stella Quimby Root, M.D.

1872 - 1941

Doctor Stella Q. Root died of coronary thrombosis in the Stamford Hospital April 17, 1941, after an illness of three weeks. Doctor Root was one of the first women physicians in Stamford and had practiced there since January 1, 1897. She was 69 years old.

Stella Quimby Root was born in St. Johnsville, N. Y., on March 9, 1872, a daughter of the late Lyman C. and Elizabeth Quimby Root. She had made her home in Stamford since 1887. A graduate of Stamford High School, she received her medical degree from the New York Medical College and Hospital for Women in 1896. Upon graduation Doctor Root was made a practising physician at the college. From 1904 to 1913 she served the college as professor of obstetrics.

In 1905 Doctor Root studied in London and Vienna, and in London, Paris and Edinburgh in 1929 and 1937. In 1929 she spent eighteen months traveling and studying in Europe.

She was a trustee of the old Stamford Hospital, serving on the gynecological staff. She also served in a similar capacity in the new Stamford Hospital. For many years she lectured in gynecology in the Training School of the Stamford Hospital.

Doctor Root was active in the founding of the Visiting Nurse Association of Stamford and at the time of her death was vice-president of the association. She was a member of the American Institute of Homeopathy, a Fellow of the American Medical Association, a member of her state and county medical societies as well as the Stamford Medical Society. She was also a member of the Medical Women's International Association and regional director of the New England section of the American Medical Women's Association. Locally Doctor Root was a member of St. John's Episcopal Church and of many local societies and clubs. She gave freely of her time and energy to many philanthropic organizations and served as consulting physician to several agencies.

Doctor Root entered upon the practice of medicine at a time when women were not always graciously accepted as members of the medical pro-

fession. By her unselfish devotion to her profession and by her high ideals she won the respect and coöperation of her male colleagues and attained an enviable place in the community as physician and leader. She thus paved the way for younger women physicians who came to Stamford to practice medicine. Her friendly interest in these younger physicians played a large part in shaping their careers. They could always count on her loyalty, support and advice. She was especially interested in women in medicine and had many friends among the younger as well as the older women physicians.

Doctor Root kept abreast of the rapid changes in the practice of medicine and, although she practised homeopathy primarily, she never failed to offer her patients the best that she could glean of advances in therapy outside the field of homeopathy. She rarely missed an A. M. A. convention or meetings of state and local medical societies. She brought from these meetings new ideas in diagnosis and treatment which she applied with renewed enthusiasm and vigor in her large practice.

Doctor Root was the finest type of family physician and, from her wealth of experience she gave her patients something that could not be measured in scientific terms. She had a most convincing manner and her patients had the utmost confidence in her. It may truly be said of her that she practised medicine as an art as well as a science. In her death the medical profession has lost an outstanding woman physician.

Madeline Fiske, M.D.

Thomas Adams Woodruff, M.D.

1865 - 1941

Doctor Thomas Adams Woodruff, always an outstanding member of the New London County and Connecticut State Medical Societies, died at New London, Connecticut, April 14, 1941, after a long illness. He was particularly active in the Eye, Ear, Nose and Throat Section of the Connecticut State Medical Society, in fact, it was through his efforts that this Section was originally organized and served as a nucleus for the development of other sectional groups within the State Society. He was at one time Chairman of the Eye, Ear, Nose and Throat Section.

Doctor Woodruff had been in practice for over fifty years, thirty five of which had been confined to ophthalmology. He was born in St. Catharines, Ontario, on June 4, 1865, the son of Samuel DeVeaux Woodruff and Jane Sanderson Woodruff.

After attending the University of Toronto, Doctor Woodruff studied at McGill University, from which in 1888 he received the Doctor of Medicine and Master in Surgery Degrees. In 1888-90 he did post-graduate work in hospitals and clinics in London, Berlin and Goettingen, Germany. In 1890 he became Licentiate of the Royal College of Physicians.

Doctor Woodruff began in 1890 four years of general practice in Chicago. In 1894-5 he was in attendance in eye and ear hospitals in Vienna, Berlin and London. In 1895 he began the practice of ophthalmology and otolaryngology in Chicago, continuing there until 1918. He was formerly ophthalmic surgeon to St. Luke's and St. Anthony hospitals in Chicago and served as Professor of Ophthalmology at the Postgraduate Medical School. While a major in the United States Army Medical Corps, 1917-18, he served as head of the eye department at the Base Hospital at Camp Grant, Illinois, and chief of the section of surgery of the head at the Base Hospitals at Camp Beauregard, Louisiana, and Camp Meade, Maryland. In December, 1918, Doctor Woodruff took up his residence in New London, where he continued the practice of ophthalmology. He was consulting ophthalmologist to the Lawrence and Memorial Associated Hospitals.

Doctor Woodruff served as third vice-president of the American Medical Association in 1908. He was a Fellow of the American College of Surgeons, the American Academy of Ophthalmology, and a member of the Illinois State Medical Society, the Connecticut State Medical Society, the Chicago Ophthalmic Society (President, 1908), and the New London Medical Association. Doctor Woodruff was particularly interested in the problem of prevention of blindness and was one of the pioneers in bringing about the existing legislation in various states for the compulsory administration of prophylactic medication into the eyes of the new-born. The private clubs and organizations to which he belonged included the Society of Colonial Wars, The Military Order of Foreign Wars, the Zeta Psi Fraternity, the Medical Veterans of the World War, the University and Calumet Clubs of Chicago, the Thames Club and the Shenecossett Country Club of New London. He was formerly a vice-president of the Lincoln Paper Mills Company, Ltd., of Merritton, Ontario.

Doctor Woodruff, co-author with Doctor Casey A. Wood of "Commoner Diseases of the Eye," published in 1904, had written many papers on ophthalmology and formerly was editorial secretary of the

Ophthalmic Record. He had contributed to the System of Ophthalmic Operations and the American Encyclopedia of Ophthalmology.

Doctor Woodruff was married to the late Caroline Mabel Wright Ogden.

During his lifetime Doctor Woodruff was cherished by a host of friends. His popularity was due to his natural ability as a leader of men, his sincerity and fairness, and his relentless drive for what he considered a worthy cause. The passing of this fine man is mourned by all who knew and admired him.

Shirley Harold Baron, M.D.

The Family Doctor In Industry

The health needs of our expanding industries cannot be completely served by the simple addition of full time physicians to the factory staff. Medical care for sick and injured workers extends into the home and coöperation with the family doctor is necessary to reinforce the national health. This important factor in the health of workers in war-time industries was brought out by Doctor Charles F. Yeager, medical supervisor of the Remington Arms Company of Bridgeport in a recent address before the Greater New York Safety Council.

Increased production has posed new problems for industrial medicine and workers are being called upon to drop their usual routines and take up activities to which they are unaccustomed. This has resulted in a period of dislocation upsetting to their health and requiring an expansion of the purposes of industrial health to meet the emergency.

There can be little doubt that much of "industrial" health is actually "personal" health and this is the field of the family doctor. He knows his patient in his home life, he understands his emotional stresses and his adjustment to his social environment. A worker is in a plant less than one fourth of his time and knowledge and supervision of his health during his extra-mural hours is the business of the family doctor. He is, as Doctor Yeager says, an important part of the medical defense forces.

X-ray Manual Popular With Connecticut Physicians

The new manual on chest x-ray interpretation has been well received by doctors in Connecticut. More than 300 copies have been requested from State Office.

SPECIAL NOTICES

THE AMERICAN COLLEGE OF PHYSICIANS announces its

Twenty sixth Annual Session
to be held in

ST. PAUL, MINN., April 20-24, 1942

Doctor Roger I. Lee, of Boston, is President of the College, and will be in charge of the program of General Sessions and Lectures. Doctor John A. Lepak, of St. Paul, has been appointed General Chairman, and will be in charge of the program of Hospital Clinics and Round Table Discussions, as well as local arrangements, entertainment, etc. Mr. Edward R. Loveland, Executive Secretary of the College, 4200 Pine Street, Philadelphia, will have charge of the general management of the session and the technical exhibits.

Other medical societies are urged to note these dates in order that conflicts in meeting dates may be avoided for mutual benefit.

AMERICAN CONGRESS OF PHYSICAL THER- APY TO CONDUCT INSTRUCTION COURSE MORNINGS THROUGHOUT ANNUAL SCIEN- TIFIC SESSION TO BE HELD IN WASHINGTON, D. C.

The 20th annual scientific and clinical session of the American Congress of Physical Therapy will be held September 1 to 5 inclusive, 1941, at The Mayflower, Washington, D. C.

The mornings will be devoted to the annual instruction course, and the afternoons and evenings will be devoted to the scientific and clinical sessions. The seminar and convention proper will be open to all physicians and qualified technicians.

All the phases of physical medicine will be covered in the general program, including a special symposium on poliomyelitis. The program will be of interest to the general practitioner as well as to the specialist in physical therapy.

For information concerning the seminar and preliminary program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

At the same time the 25th annual meeting of the American Occupational Therapy Association will be held at The Mayflower. A combined meeting will be held on Wednesday, September 3, 1941. For information concerning the Occupational Therapy Association meeting, address Mrs. Meta R. Cobb, 175 Fifth Avenue, New York City.

Second New England Conference on Tomorrow's Children

The Second New England Conference on Tomorrow's Children will be held at Littauer Center, Harvard University, July 16, 17 and 18, 1941. The theme of the Conference will be "The Family in a World War." Round tables on the mornings, symposia on each afternoon, and lectures in the evenings comprise the program. Registration fee \$2.00. University dormitories and dining halls will be available. Address Secretary, New England Conference on Tomorrow's Children, Harvard Summer School, Wadsworth House, Cambridge, Mass. The State Vice-chairman for Connecticut is Professor Bessie Bloom Wessel, Connecticut College, New London.

Examinations, American Board of Obstetrics and Gynecology

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 3, 1942, at 2:00 P. M. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 6, 1941. Applications for Group A must be in the Secretary's office by March 1, 1942.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Atlantic City, N. J., immediately prior to the 1942 meeting of the American Medical Association.

As previously announced in the Board booklet, this fiscal year (1941-1942) of the Board marks the close of the two groups of classification of applicants for examination. Thereafter, the Board will have only one classification of candidates, and all will be required to take the Part I and Part II examinations.

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QUARTO NOTES

A TEXTBOOK OF MEDICINE BY AMERICAN AUTHORS. (5th edition.) Edited by Russell L. Cecil, A.B., M.D., Sc.D., Professor of Clinical Medicine, Cornell University Medical College; Associate Attending Physician, New York and Bellevue Hospitals, New York City; Associate Editor for Diseases of the Nervous System; Foster Kennedy, M.D., F.R.S.E., Professor of Clinical Neurology, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician in Charge, Neurological Service, Bellevue Hospital; Consulting Physician, New York Neurological Institute. Philadelphia and London: W. B. Saunders Company. 1940. 1744 pp. \$10.00.

Reviewed by JOSEPH B. HOLLINSHEAD

Much of the recent critical review of Doctor Meakins "Textbook on the Practice of Medicine" appearing in Volume 5, Number 2, of this same journal can be carried over in considering any textbook of Medicine, and is specifically applicable to "A Textbook of Medicine" edited by Doctor Cecil. This criticism is definitely no reflection upon those men who spend so much time and energy on such an endless task nor upon others who shoulder the burden with them. Instead it is inherent in the undertaking whereby an attempt is made to put forth too much in too little space. Moreover, revision of material between editions covers at best only a part of the text, and much is recopied from year to year.

It seems more practical to consider an acknowledged restriction of the usefulness of such a book, than to suggest expanding it to cover any demand that might be placed upon it. And in this light, Doctor Cecil's book is entirely adequate. Under every disease considered there are basic paragraphs following a general outline of: History, Etiology, Physiology, Anatomy, Symptoms, Diagnosis (though little on Differential Diagnosis), Course, Complications, and Treatment; this last paragraph might often be more detailed. In the hands of a competent teacher Doctor Cecil's book is a good, full outline, or, as he suggests, a summary. But somehow the finer and not always less important details must be brought out and outmoded material and conclusions deleted. It is not nor can it be a source or reference book except as it presents "an authoritative summary of present day medicine".

Following most sections there is a list of references which is of little value, for there is no correlation with the foregoing text; it does, however, suggest additional reading.

In this edition there are ten entirely new treatises on subjects not previously covered; among them are Equine Encephalomyelitis, Disseminated Lupus Erythematosus, Bromide Poisoning, Riboflavin Deficiency. There are also thirty new articles on subjects covered in previous editions, including that on Tuberculosis which is excellent and practically a monograph, and a fuller more intelligible section on Diseases of the Kidneys.

There are good articles on most of the more common

diseases: the Virus Infections, Pneumonia, Tetanus, Brucellosis, Tuberculosis already mentioned, Rheumatic Fever, Deficiency Diseases, Diseases of the Circulatory System, and of the Kidneys also mentioned above. A considerable number of pages is devoted to the Diseases of the Nervous System, many of which are dismissed with a line or two. The time spent reading these sections and those of less general interest is obviously profitable.

Bearing in mind that the book is the work of many writers whose style and ability to put across their knowledge varies greatly, and that it cannot be as up to date as a journal or even as a loose-leaf volume, nor as detailed, all inclusive and well annotated as a series of monographs on specific subjects, it is an excellent and authoritative Textbook of Medicine.

THE HEART IN PREGNANCY AND THE CHILD-BEARING AGE. By Burton E. Hamilton, M.D., Cardiologist, Boston Lying-In Hospital and K. Jefferson Thomson, M.D., Associate Physician, Metropolitan Life Insurance Company Sanatorium, Mount McGregor, New York, with a Section entitled Delivery and Obstetrical After-Care of Cardiacs, by Frederick C. Irvings, M.D., F.A.C.S., Professor of Obstetrics, Harvard Medical School and Obstetrician in Chief, Boston Lying-In Hospital. Boston: Little, Brown & Co. 1941. 402 pp. \$5.00.

Reviewed by STANLEY B. WELD.

As one reads through this volume one is impressed by the results obtained from a vast experience in both cardiology and obstetrics. The book is divided very conveniently into three parts. The first presents a record of the knowledge and beliefs of the authors on the practical aspects of the care of cardiacs throughout pregnancy, delivery, and the puerperium. The second part gives details of the experiences of the authors with and information about the physiology of the effect of pregnancy on the circulation in normal women and in cardiacs. The third portion of the volume contains a separate discussion of the various heart diseases in women in the childbearing age and the effect of pregnancy on the course of the diseases. Each chapter carries with it an extensive bibliography. Charts and tables abound to emphasize the printed word.

In the first section of the book emphasis is placed on the four diagnostic criteria for a diseased heart, viz., (1) enlargement, (2) a diastolic murmur, (3) significant disorders of the beat, and (4) signs or history of heart failure ("anginal" or "congestive" or "paroxysmal dyspnea"). The authors prove very conclusively that at thirty-five the incidence of heart failure in pregnancy doubles in the chronic rheumatic heart disease group; also that heart failure seldom occurs for the first time at or following delivery. The load of pregnancy grows heavier from the sixth to the eighth months and, therefore, it is during this period that the cardiac must have special care.

In the second section the authors bring out certain significant facts, viz., that there appears to be a slight retardation of blood flow in cardiacs, that early congestive heart disease is accompanied by a significant increase in total blood volume and a significant decrease in vital capacity, and that vital capacity observations have proved to be of definite

value in detecting early congestive heart failure, ante-dating other evidence of pulmonary congestion by several weeks.

The third section deals with the heart in such diseases as preeclampsia, eclampsia, hypertension and nephritis in pregnant women. It also discusses rheumatic heart disease, the cardiac neuroses, congenital defects, acute and subacute bacterial endocarditis, the thyroid heart, rare cardiovascular diseases, and disorders of the heart beat—all in pregnancy and the childbearing age.

To the obstetrician this volume has much of value to offer. He will no longer choose to perform cesarian sections in the eighth month of a pregnancy because of cardiac disease alone. He will hesitate to induce abortion or to include labor, even at term, by as simple a method as artificial rupture of the membranes in an uncomplicated cardiac. He will remember that cardiacs present a greater risk from puerperal sepsis than do pregnant women with normal hearts. Every obstetrician and every general practitioner engaged in the practice of obstetrics should not only read this book carefully but keep it at hand for reference. It is a valuable addition to our knowledge of modern obstetrical care.

AN INTRODUCTION TO DERMATOLOGY. (4th edition.) Edited by *Richard L. Sutton, M.D.*, Emeritus Professor of Dermatology, University of Kansas School of Medicine and *Richard L. Sutton, Jr., M.D.*, Assistant Professor of Dermatology, University of Kansas School of Medicine. *St. Louis: The C. V. Mosby Company.* 1941. 904 pp. 723 illustrations.

Reviewed by F. EARLE KUNKEL

This book is intended for students, collegiate and post-graduate. It contains a review of dermatology sufficient to outline the scope of the speciality beyond provincial boundaries.

This fourth edition has been condensed from the tenth edition of *Diseases of the Skin* by the same authors.

Emphasis is laid on the purpose of practical medicine, which is to cure the average patient of the common complaints by scientific or by practical means.

The authors have freely given their opinions, interpretations, and ideas, particularly regarding treatment, throughout the text. Their original ideas concerning the treatment of acne vulgaris are of interest.

The number of illustrations in this edition has been more than trebled. The bibliography, an innovation in this edition, has taken into account medical literature which has appeared since the middle of 1939 and has been selected with a view to utility. Leading articles of recent date, especially those which themselves incorporate reviews of literature, have been chosen.

This book has been admirably, but not too drastically condensed from a text well recognized in the specialty of dermatology.

FOREIGN BODIES LEFT IN THE ABDOMEN. By *Harry Sturgeon Crossen, M.D.*, School of Medicine, Washington University and *David Frederic Crossen, LL.B.*, School of Law, Washington University, St. Louis, Missouri. *St. Louis: The C. V. Mosby Co.* 1940. 762 pp. Illustrated. \$10.00.

Reviewed by CHRISTOPHER J. MCCORMACK.

The title of this book is poorly chosen. The text is not limited to foreign bodies left in the abdomen but includes foreign bodies left in other parts of the body as well. For example, there is a whole chapter devoted to "Foreign Bodies Left In Other Operations" and these include articles left in operations on the uterus, vagina, bladder, rectum, kidney, hernia, abdominal wall, breast, chest, neck, nose, throat, mouth, back, spine, upper extremity and lower extremity. In addition to this there is a chapter on "Swallowed In The Abdomen". This fact does not detract from the value of the book but it seems that the title should be more general and inclusive such as: "Foreign Bodies-Swallowed and Left at Operation".

Roughly, the book consists of two parts. The first contains 9 chapters of 621 pages and deals with the medical aspect of the problem; the second, dealing with the legal viewpoint, contains 6 chapters of 141 pages. The medical discussion is based on a series of 473 cases of foreign bodies

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left in the abdomen; 153 objects left in operations which were not abdominal; and 188 swallowed foreign bodies. Sponges formed the largest group of foreign bodies left in the abdomen but the whole group included needles, forceps, drains and other miscellaneous objects. In the discussion of the swallowed foreign bodies, points in common with articles left at operation, differential diagnostic problems, x-ray visibility problems and parallel treatment problems are considered.

The legal aspect of the subject is based on a series of cases of foreign bodies left in abdominal operations and 38 cases of foreign bodies left in operations which were not abdominal. These cases include only those which have been decided by courts of appellate jurisdiction and have been reported in one of the state or national reporter systems. Some of them had previously been considered from the medical standpoint in the first part of the book.

There are a number of errors noticeable throughout the text and because of these reference from one table to another or reference to an illustration is sometimes confusing and makes the sequence of the book difficult to follow at times. There are numerous errors in the list of illustrations.

This book represents a great deal of work on the part of the authors. It is not the type of book that can be skimmed over and read lightly. It must be studied to get the maximum benefit. It contains all the pertinent data in reference to foreign bodies and should serve as a useful guide for those whose work touches in any way the prevention, treatment and diagnosis of foreign bodies. Especially interesting are the chapters on the preventive measures devised for the loss of objects, the chapter on deception and malingering.

This is the first edition of this book and the reading of it should stimulate those who have had an experience with this subject to report any such experience, so that the second edition may be more complete. The book is well bound and printed, the illustrations are clear and well chosen, the bibliography extensive, and the index well arranged and complete. This first edition should be a valuable addition to any medical library.

PSYCHOLOGICAL AND NEUROLOGICAL DEFINITIONS AND THE UNCONSCIOUS. By *Samuel Kahn*, M.D., PH.D., Mt. Sinai Hospital Mental Health Clinic, New York City. Boston: Meador Publishing Co. 1940. 219 pp. \$2.00.

Reviewed by **LOUIS H. GOLD**

This small book directs itself toward the support and favor of psychoanalysis and is dedicated to the memory of the immortal Sigmund Freud. It contains a goodly amount of historical material including a limited biographical sketch of Freud's early experiences and contributions with a listing of his various publications. There are many neuropsychiatrists who will take issue with the author's claims for psychoanalysis, especially those workers who have found executive, dynamic and psychobiologic approaches effective. As one reads on, there is a brief gain in momentum and substance. The review of philosophical material and the comparison of this data with some of Freud's concepts merit interest. The discussion of the subconscious is somewhat labored but apparently necessary. From page 66 to page 148 there extends

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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a voluminous glossary with a description of many terms encountered in neuropsychiatric reading. However, the definition of such terms as autopsy, dura mater, spleen, etc., appears unnecessary. A comprehensive bibliography marks the end of the book and this should be one of its features. Attention may be called to errors in typography and spelling.

Although the content is generally good, perhaps the claims made for this book in the preface are too great. It is not an important contribution to the field of neuropsychiatry.

TECHNIQUES OF CONCEPTION CONTROL. By Robert L. Dickinson, M.D., Former President, American Gynecological Society and Woodridge E. Morris, M.D., General Medical Director, Birth Control Federation of America. Baltimore: William & Wilkins Co. 1941. 56 pp. 50 Cents.

Reviewed by STANLEY B. WELD.

To physicians in Connecticut it may seem a bit daring, even absurd, to offer a review of this manual on methods, the use of which are forbidden by the laws of our State. Knowledge of what may be offered the women of America in other more progressive States can do no harm, in fact, it may serve to produce conviction in the minds of some physicians where doubt now exists. We must not forget that one-fourth of the nation's maternal deaths are due to abortion. We must not overlook the fact that pregnancy has a disastrous effect upon a large group of poor maternity

risks as well as deleterious effect, if too frequent, upon even the healthy mother. Students should be instructed in contraceptive methods "to the end," as Doctor Nicholas J. Eastman states in the foreword, "that some patients suffering from chronic diseases may be spared pregnancy altogether and that others may so space their childbearing as to serve the best interests of all concerned."

This manual is written for the general practitioner with limited or no training in the control of human fertility, and for the undergraduate medical student whose requirements call for details in principles and techniques. It is comprehensive in scope and exceedingly well illustrated. All methods of contraception are dealt with in detail and their relative merits of efficiency and acceptability listed. The various commercial products of condoms, diaphragms, jellies, tampons, sponges, pastes, creams and suppositories are all discussed. The different methods of producing prolonged protection, the indications for contraception, and the control of sterility are carefully dealt with.

The conclusions reached at the end of the manual are worth repeating. (1) Clinically approved methods show 85 to 95 percent protection. (2) Women come to clinics after an average of 2.6 pregnancies, with over 2 living children; nearly half have 4 or more living. (3) Histories and follow-up disprove the common accusations against birth control. (4) Evidence is lacking, after a 16 year hunt, for case records of sterility from methods other than intrauterine devices.

Table of Contents : August 1941

ORIGINAL PAPER

SWIMMING PLACES AND PUBLIC HEALTH	Warren J. Scott, s.b., Hartford	570
-----------------------------------	---------------------------------	-----

REPRINTED PAPERS

THE DOCTORS WELCH OF NORFOLK	Harvey Cushing, M.D.	557
WILLIAM BEAUMONT	Russell H. Chittenden	561

CASE REPORT

MULTIPLE ANEURYSMS OF SPLENIC, GASTRIC, RENAL, AND SUPERIOR MESENTERIC ARTERIES	Daniel F. Levy, M.D., New Haven	567
---	---------------------------------	-----

EDITORIALS

Quo Vadis?	573	Liquor and Hats	575
Certification Under Fire	574	Rheumatic Fever in Connecticut	575
Causes of Death in Connecticut	575	Doctor Linde Reappointed to Tuberculosis Commission	576

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	577	INDUSTRIAL HEALTH	591
THE DOCTOR'S OFFICE	578	OUR NEIGHBORS	593
CONNECTICUT HOSPITAL ASSOCIATION	579	NEWS FROM COUNTY ASSOCIATIONS	593
MEDICAL PREPAREDNESS	584	NEWS FROM YALE UNIVERSITY SCHOOL OF MEDICINE	594
THE LEGISLATURE	587	LETTERS TO THE EDITOR	595
THE FORUM	590	QUARTO NOTES (Book Reviews)	596

MISCELLANEOUS

OBITUARIES	595	OFFICERS AND COMMITTEE CHAIRMEN	
		Connecticut State Medical Society	4
ROSTER OF MEMBERS, 1941	597	Connecticut Hospital Association	4

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VOL. V

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No. 8

THE DOCTORS WELCH OF NORFOLK

HARVEY CUSHING

Over the river, on the hill,
Lieth a village, white and still.
All around it the forest trees
Shiver and whisper in the breeze.
Over it sailing shadows go,
Of soaring hawk and screaming crow;
And mountain grasses, low and sweet
Grow in the middle of every street.

OVER THE northerly part of Litchfield County in Connecticut sprawl the rugged and heavily wooded foothills of the Berkshires, and in early May they are possibly even more lovely than when the first frosts of late September have suddenly turned to crimson the swamp maples of their lower valleys. But whatever the time of year, no part of Litchfield County is more quietly satisfying than the township of Norfolk which must have changed scarcely at all since Hopestill Welch decided to settle there one hundred and sixty-two years ago.

If the beauty of the countryside is thus felt by the casual visitor, how much more deeply must those feel who, born and bred in Norfolk village, have roamed the neighboring hills, fished the streams, and swum the ponds in boyhood days. And so the great-grandson of this Hopestill Welch, though in the course of his eighty-four years he had wandered far and attained world renown, never lost his affection for the place of his birth and requested that it also be his place of burial just as it had been of his medical forbears.

Norfolk village, having been protected against the vandalism of modern days, has lost none of its old-time charm. Many of the villagers who have moved away and prospered have regularly returned to pass the summer on some of the nearby hillsides, but the village itself has changed but little. Loving hands have kept it trim and neat. The village green with its magnificent trees, its typical New England meeting-house and town hall is the same as always; and so too is the original village "burial-yard" laid out in 1757 as God's Acre.

Behind a low stonewall just beyond the last of the houses on the road to Canaan it lies, inconspicuous to passers-by, on the lower slope of Haystack Mountain where it borders on the brook. In the shadow and solitude of great trees the headstones are scattered in groups as though they had accidentally grown there. No gravel walks, no artificial planting and regimented narrow plots have been needed here though the original acre has been considerably extended.

Reprinted by permission of The New England Journal of Medicine, May 24, 1934.

Whatever may have happened to the many from Norfolk who joined in the great migration to the New North-West—as did ten of Hopestill Welch's thirteen children—one gets the feeling that those who stayed behind must have lived to a great age else there would by this time be more crowding in this one hundred and sixty square perches of land. Norfolkins while not boastful have good reason to take pride in the proverbial longevity of their people which is not surpassed or equalled by any other community in New England. In the space of two years not so very long ago, six persons died there whose average age was over ninety-three. Compared to this the Welches, as we shall see, mostly died young—in their early eighties; and it was a family tradition that they would be likely to keep going in perfect health just that long and no longer.

On this particular May fourth of 1934 with the countryside glistening after a warm Spring rain, the early afternoon sun struck across the hillside lighting up the feathery pink blossoms of the maples, the delicate early green of willows and birch; and the tufted white blossoms of an occasional shad-bush, set off against the dark hemlocks and the brilliant green of the Spring turf, made it clear that the season had come to cast for speckled trout.

There is a touch of sadness and melancholy about Autumn which would seem the more natural time of year for an old man to die. But so far as anyone could ever tell, sadness and melancholy were moods of which he was incapable and it was as though he whose youthful spirit and reactions so belied his years had deliberately waited for Spring—waited at least as long as he could, for the season has been delayed by the hard winter and the venerable elms have not as yet burst their winter buds.

One such giant has come almost to envelop in protecting embrace the headstone of a certain Jerusha P.—, who had been buried at its feet, evidently the wife of Captain John Porter who in 1793 came to be placed beside her. Another aged tree of the same kind once shaded the nearby knoll marked by a modest brownstone shaft where lie the Welches and where a new grave has just been dug to hold the ashes of still another of them.

A few people had gathered at the knoll—his relatives and three or four others. Appropriate verses from Ecclesiasticus were read by the local clergyman and followed by a simple prayer. Then two of his great-nephews who were at the same time his namesakes lowered the casket into its place. That was all—except for one incident.

In the small gathering was a frail little old lady whose many wrinkles could not conceal that she must once have been beautiful. She arose with some difficulty from the camp chair that had been provided for her and, refusing aid, walked over to where lay a spray of red roses she had brought and lifting them she placed them with her own hands beside the grave. Then turning away she said as to herself, "I shall now go." Only six months younger she was than this friend of her childhood; they had long ago been playmates—perhaps, on her part, something more than that.

It was the same little old lady who four years before had been taken in a wheel chair all the way to Washington so that she might hear in Con-

tinental Hall what the President of the United States and other notables would have to say about her lifelong friend; and also what in return he would have to say for himself on that day when speeches in honor of his eightieth birthday were broadcast to all quarters of this country and abroad.

While this public celebration with its spontaneous outburst of affection was in its way a sort of canonization, honors had been heaped upon this particular Doctor Welch throughout his life. He could not avoid them without being ungracious—and this he never was—but they left him unchanged in his simplicity. He always behaved on these occasions as though he were merely representing someone else—someone else who deserved the honor and for whom it was really intended.

It had been urged that the National Cemetery at Arlington was the proper place for him to lie in view of his distinguished service during the War. He had merely volunteered on an April day in 1917 to help his friend, the Surgeon-General, open his rapidly overwhelming mail; and the close of the War found him still there—much to his surprise and somewhat to his amusement—a Brigadier-General. But a military funeral, with gun carriage, firing squad, the last post and all that, just because he had done his duty as he saw it, would have been incongruous and unsuited to his real character and life, public though much of it had come unsought to be. It was wholly consistent and typical of him that he should choose to rest where to the future passer-by he would be just another of the many Doctors Welch of Norfolk.

Even now, should you happen to ask the aged apothecary in the village which of the Doctors Welch was the more celebrated, he would certainly say William Wickham, the father of this William Henry. And should you venture to demur, knowing that William Wickham, weary of compounding his own drugs, had set him up in business some fifty and more years ago, he would be likely to reply:

"If you don't believe me, just ask any middle-aged person you may chance to meet up with for thirty miles around and see if they don't agree. Most of 'em will remember when they used to put a light in the window for him should be happen by in the dead of night. He was never known to send out any bills—pretended to forget that people owed him money and those who paid had to press it on him. There's his house just down the street—as it was when at the end of his seventy-four years he left it to his successor—a good man, too, though he could not stand the wear and tear so long as if he'd been a placid and good-humored Welch.

"It was in that house his son Willie was born and there's a tablet on it saying as much; but if you think the drinking fountain in front, for thirsty horses coming up the hill, was put there in memory of your friend rather than for William Wickham his father, you make a great mistake. If you haven't forgotten your Latin, just go and read the inscription cut around its rim.

"And you will find just off the road the little house in which *his* father, Doctor Benjamin Senior, lived until he died at eighty-two, beloved like all

the rest of them. It was his second wife, Elizabeth Loveland, a beautiful woman, who lived to be eighty and was everybody's friend and known to every Sabbath-School boy in the town as 'Grandma Welch'—it was she who brought up the Doctor Welch you've just seen buried today, for his mother died when he was barely six months old.

"William Wickham wasn't the only one of old Doctor Benjamin's sons who took up medicine; there were four others who spent their lives within thirty miles of here—all men of the same kind and they are all buried together in the Acre. Asa was the eldest. He first started out in Tyringham but was invited to settle in Lee where he practised until his death. He was interested in public affairs—as indeed they all were for that matter—though he was the only one who happened to be sent to the State Senate. Benjamin Jr. was the next. He got his M.D. at Yale in 1823 and was in active practice for fifty-four years—first here for a time, then at Litchfield and finally at Salisbury. He became celebrated as a surgeon and there was a common saying hereabouts: 'Don't give up hope before you've sent for Doctor Benjamin.'

"James was the third son. He got his degree at the old Berkshire School in 1830 and settled at Winsted where he built up a large practice in which he was active till he reached eighty; and what's more at least three of *his* sons became doctors. Then came William Wickham—the best of them all to my thinking. And after him the fifth and youngest was John Hopestill, who also graduated at the Pittsfield school in 1848 and then practised in Salisbury, in Cornwall and in Norfolk till 1871 when he moved to Hartford where he finally drifted out of medicine into a manufacturing business."

So it would seem there must have been at least ten doctors in these three generations, all apparently men of very similar type, good judges of people and good public servants, men able to instill confidence and win regard, all of them blessed with a rare capacity to gain and retain friendship with young and old, all of them apparently men who were respected, admired and beloved. And then, to follow the old apothecary's advice, you go down the road and find cut on the rim of the fountain erected in memory of your friend's father—the last of the Doctors Welch to pass his life wholly in Norfolk—what might be no less appropriate to William Henry his son:

FONS SUM SOLATI TALIS ET IPSE FUIT.

WILLIAM BEAUMONT

RUSSELL H. CHITTENDEN

WE ARE HERE to pay a tribute to William Beaumont, a physician trained in the school of experience, a "backwood physiologist" as Sir William Osler termed him; a man who knew little or nothing of the niceties of physiological experimentation but who having an opportunity seized upon it with all the ardor and persistency of the trained investigator, with the sole purpose of serving humanity and science.

Look back a hundred years or more to 1822, and picture to yourselves what the conditions must have been in that northern region, along the shores of Lake Superior, Lake Huron, Lake Michigan, and the Mississippi country; a veritable wilderness, traveled over by the employees of the American Fur Company. Here, at a point where the waters of the two lakes, Huron and Michigan, flow together stood Mackinac, the center of the trading posts established in this territory, and in the spring of the year French Canadians, Indians and fur traders gathered there making a mixed population of several thousands. Here was situated Fort Mackinac, occupied by a troop of United States soldiers to enforce order among these turbulent people.

At this fort Doctor William Beaumont was the surgeon, but in addition to looking after the health of the garrison, he engaged in some private practice, for there was no other physician within reach. Here, were none of the scientific refinements that might be looked for in the large cities of the country, even at that date. The hospitals, laboratories, research institutions, and medical specialists of this generation were obviously non-existent, and would have been quite foreign to that background; but even if they had been available, the knowledge then possessed by the physician or the surgeon would have left much to be desired, as measured by present day standards.

The surgeon of that distant date had to contend with an army of invisible foes, all combining to render his work of no avail; infection, suppuration, putrefaction almost invariably appeared to hinder or destroy the benefits hoped for in any surgical operation, for Pasteur, Koch, and Lister had not yet done the work that was to throw light on the cause of these conditions,

[Reprinted by permission of *The Yale Journal of Biology and Medicine*, January, 1929.]

An address presented at the dedication of the Beaumont Memorial Tablet, June 29, 1926, at Lebanon, Connecticut. The tablet bears the inscription:—

In that part of Lebanon known as "Village Hill" some three miles from this spot on the road leading from Lebanon to Willimantic was born Nov. 21, 1785

DR. WILLIAM BEAUMONT

a surgeon of the United States army who later became illustrious as a pioneer investigator of the physiology of digestion through his painstaking and valuable observations continued throughout many years and largely at his own costs upon the person of Alexis St. Martin who recovered under the skillful treatment of Dr. Beaumont from a severe gunshot wound of the abdomen which healed with a permanent gastric fistula.

In appreciation of his valuable services to science and to humanity this tablet has been placed here by

THE BEAUMONT MEDICAL CLUB



PORTRAIT OF DOCTOR WILLIAM BEAUMONT PAINTED BY MR. DEANE KELLER OF YALE UNIVERSITY. PRESENTED TO THE YALE MEDICAL LIBRARY BY THE BEAUMONT MEDICAL CLUB OF CONNECTICUT

and to teach methods of prevention, such as prevail today. The surgeon must operate as best he could and then trust in a kind Providence, for he knew nothing of microbes or bacteria and antiseptic or aseptic methods were undreamed of. Again, anaesthesia, that great boon for suffering humanity, which brought about the "death of pain", was not known. The beneficent action of ether and chloroform in subduing the terrors of the subject and in rendering the work of the surgeon safer and easier was not yet available.

Knowledge of the functions or processes of the body was in many respects crude and imperfect. This was especially true of the physiology of digestion in the years preceding 1822. Old theories and hypotheses, more romantic than scientific, clung with great persistency; the stomach, obviously

a receptacle for food, was the outstanding figure in the digestive scheme. Around this organ centered most of the earlier theories regarding digestion, in which trituration, maceration, fermentation, and putrefaction were the dominant features. One is reminded of the somewhat humorous remark made by William Hunter, "Some physiologists will have it, that the stomach is a mill, others, that it is a fermenting vat, others, again, that it is a stewpan; but in my view of the matter, it is neither a mill, a fermenting vat, nor a stewpan; but a stomach, gentlemen, a stomach." To be sure, this statement does not throw much light upon what the stomach was supposed to do, except perhaps in a negative way. However, at the time when Beaumont was the surgeon at Fort Mackinac, there was a fairly clear understanding that the juices of the stomach were possessed of chemical power by which the food-stuffs were made to pass into solution.

But there were a host of questions relating to stomach digestion that needed answering; questions that in their very nature were expressive of the uncertainty and ignorance that prevailed regarding this most important function of the animal body. Who were to answer these questions, who bring to light the many facts needed on which to build a rational theory of gastric digestion with all its apparent complexities? In Great Britain, in Europe, trained physiologists and chemists were at work, but knowledge was coming slowly and it remained for America, through her "backwood physiologist," to contribute an epoch-making series of discoveries, the fame of which went round the world of science. In the words of Doctor Seelig, in his *Historical Outline of Medicine*, published last year, "America, during the early period of the nineteenth century epoch had to her credit just a single physiologist, William Beaumont; but we may say of this one, as we say of the one cub that the lioness brings forth, 'the lion whelps only one at a time, but that one cub is a lion'."

Doctor Beaumont had had no special training as a physiologist, he was not an experimenter in the usually accepted use of the term, neither was he trained in the ways and methods of science, but he undoubtedly possessed great latent genius and it needed merely an opportunity to blossom and bring forth fruits worthy of any well-trained mind. The opportunity came and subsequent events showed that he was ready to grasp it, and courageous enough to take advantage of all that it offered.

On the 6th of June, 1822, Alexis St. Martin was standing in the company's store at Mackinac, when he was accidentally wounded by the discharge of a musket loaded with powder and duck shot, the muzzle of the gun being not more than a yard away. Doctor Beaumont was immediately summoned and did all that was possible under the circumstances, extracting some of the shot together with pieces of clothing. His description of the wound was as follows: "The wound was received just under the left breast and supposed at the time to have been mortal. A large portion of the side was blown off, the ribs fractured, and openings made into the cavities of the chest and abdomen through which protruded portions of the lungs and stomach, much lacerated and burnt, exhibiting altogether an appalling and hopeless case. The diaphragm was lacerated and a perforation made directly

into the cavity of the stomach through which food was escaping." To the surprise of Doctor Beaumont, the patient was still alive the following day when he removed more of the shot and clothing and cut off the ragged edges of the wound. Without further details, let it suffice to say that day by day saw improvement in the patient's condition, and at the end of ten months the wound was partially healed, "but he was still an object altogether miserable and helpless." During all this time Doctor Beaumont had dressed his wound daily and sometimes twice a day.

"A lucky and perhaps the only circumstance to which his miraculous survival can be attributed was the protruded portion of the stomach, instead of falling back into the cavity of the abdomen to its natural position adhered by the first intention to the intercostal muscles and by that means retained the orifice in the wounded stomach in contact with the external wound, and afforded a free passage out." Every effort to close this aperture in the stomach met with failure.

The town of Mackinac not being willing or able to support St. Martin longer, it was proposed to send him by open boat to his native place near Montreal, but as this would undoubtedly have ended his life, Doctor Beaumont took him into his family and continued his ministrations for two years longer at which time he was able to walk about and help himself a little. Later on, Doctor Beaumont in commenting on the action of the Town in refusing further assistance to St. Martin states, "I took him into my own family from mere motives of charity and a disposition to save his life, or at least to make him comfortable, where he has continued improving in health and condition, and is now able to perform any kind of labour from the whittling of a stick to the chopping of logs and is as healthy, active and strong as he ever was in his life, or any man in Mackinac, with the aperture of the stomach in much the same condition as it was at the last mentioned date." Among the people of Mackinac St. Martin was frequently referred to as "the man with a stomach having no lid." He had to have an artificial lid of lint or other material to keep the contents of the stomach in place.

Not until this time, apparently, in the spring of 1825, did the thought come to Doctor Beaumont that he had in his grasp an unusual opportunity, that the miraculous preservation of St. Martin's life, his gradual recovery of health and strength, with a stomach so marvellously open to inspection was a special invitation to him, who had brought about St. Martin's recovery, to make use of the opportunity for the good of humanity. In one of his manuscripts of this date is the following: "When he (St. Martin) lies on the opposite side I can look directly into the cavity of the stomach, and almost see the process of digestion. I can pour in water with a funnel or put in food with a spoon, and draw them out again with a syphon. I have frequently suspended flesh, raw and roasted, and other substances into the perforation to ascertain the length of time required to digest each; and at one time used a tent of raw beef, instead of lint, to stop the orifice, and found that in less than five hours it was completely digested off, as smooth and even as if it had been cut with a knife."

Again, a little later, Doctor Beaumont writes as follows: "This case

affords an excellent opportunity for experimenting upon the gastric fluids and process of digestion. It would give no pain, nor cause the least uneasiness, to extract a gill of fluid every two or three days, for it frequently flows out spontaneously in considerable quantities. Various kinds of digestible substances might be introduced into the stomach, and then easily examined during the whole process of digestion. I may therefore be able hereafter to give some interesting experiments on these subjects."

He now plainly saw the opportunity and in May, 1825, he commenced his first series of gastric experiments at Fort Mackinac. In June, being ordered to Fort Niagara, New York, he took St. Martin with him and continued his experiments there, later taking him to Burlington, Vermont, and to Plattsburg, New York. There were various interruptions to the work, St. Martin leaving him at one time and going to Canada, but the experiments were continued until near the close of 1833. Agreements were drawn up between the contracting parties, one of the last ones reading as follows: "Serve, abide and continue with the said William Beaumont, wherever he shall go or travel or reside in any part of the world his covenant servant and diligently and faithfully, etc. . . . that he, the said Alexis, will at all times during said term when thereto directed or required by said William, submit to assist and promote by all means in his power such philosophical or medical experiments as the said William shall direct or cause to be made on or in the stomach of him, the said Alexis, either through and by means of the aperture or opening thereto in the side of him, the said Alexis, or otherwise, and will obey, suffer and comply with all reasonable and proper orders of or experiments of the said William in relation thereto."

The agreement bound Doctor Beaumont to pay St. Martin \$150 for the year and provide him with board and lodging. In a later agreement covering a period of two years, the remuneration was \$400.

The hundreds of experiments carried out by Doctor Beaumont, covering a period of seven years, with the conclusions he thought justified were published in book form at Plattsburg in 1833. The widespread interest in Doctor Beaumont's work is shown by the fact that in the following year the book was translated into German and published in Germany, while in 1838 an edition was issued in Scotland by Doctor Combe of Edinburgh, with numerous notes and comments.

What Doctor Beaumont accomplished in this unique study of gastric digestion has become such an integral part of our knowledge of this subject that it is quite unnecessary to particularize. Even today, nearly a hundred years since the first edition of his book appeared, his name is to be found together with that of Alexis St. Martin in every treatise on physiology. Especially noteworthy is the fact that some of the most recent results on secretion, notably the studies of Professor Pawlow, were actually anticipated by Beaumont.

A study of the many letters that passed between Beaumont and the chemists and physiologists of his day regarding the gastric juice, samples of which Beaumont had sent to the persons in question, reveals many amusing

situations where the writer endeavored to cover a lack of knowledge by glittering generalities. Beaumont was in search of light, he wanted suggestions how best to interpret this or that observation. He had forwarded to Professor Silliman a sample of gastric juice, begging him to analyze it. This Silliman had done, doubtless to the best of his ability (we must remember this was in 1833), but without any definite result. Apparently in extenuation, he closed his report to Doctor Beaumont in the following words: "I regret that I cannot contribute something important to our previous knowledge—there is much in physiology that eludes the scrutiny of chemistry. Thought may emanate from the brain, volition may cause the movement of the muscles, sentient and ever rational beings may spring from a seminal drop of very simple composition, and all kinds of aliment may dissolve with the equally mild and simple gastric juice, but who can explain the proximate, or even ultimate cause in any other way than by referring it to a positive law of the Creator—often incomprehensible equally in his nature and in his works." This, like many other replies, was not of much service to Beaumont. He had no particular hypothesis to support, he had collected a mass of facts which appeared to throw light upon many hitherto obscure questions and he was keenly anxious to interpret them aright. He had great respect for facts, especially those he had collected himself, and he was frequently disturbed and sometimes indignant at those theorizers who relied upon eloquence to support their views, without regard to the facts which lay before them. The following bit of philosophy is typical of his good sense:

"It is unfortunate (he wrote) for the interest of physiological science that it generally falls to the lot of men of vivid imaginations and great powers of mind to become restive under the restraint of a tedious and routine mode of thinking and to strike out into bold and original hypotheses to elucidate the operations of nature, or to account for the phenomena that are constantly submitted to their inspection. The process of developing truth by patient and persevering investigations, experiment and research is incompatible with their notions of unrestrained genius. The drudgery of science they leave to humbler and more unpretending contributors. . . . Honest objections, no doubt, are entertained against the doctrine of digestion by the gastric juice. . . . But we ought not to allow ourselves to be seduced by the ingenuity of argument or the blandishments of style. Truth, like beauty, when unadorned is adorned the most, and in prosecuting these experiments and inquiries I believe I have been guided by its light. Facts are more persuasive than arguments, however ingeniously made."

But we have already taken too much time. It is very fitting that here in Lebanon, where he was born, this memorial tablet should serve as a reminder to coming generations of the name and fame of William Beaumont. In the words of another, "Let us preserve the memory of the deserving; perhaps it may prompt others likewise to deserve."

MULTIPLE ANEURYSMS OF SPLENIC, GASTRIC, RENAL, AND SUPERIOR MESENTERIC ARTERIES

DANIEL F. LEVY, M.D., *New Haven*

The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the JOURNAL. The following from Grace Hospital (New Haven) is the seventh in the series. (The Editor.)

The Author. PH.B. Yale, 1915; M.D. Yale, 1919;
Attending Physician and Chairman, Clinical Patho-
logical Conference, Grace Hospital

F. R., a 31-year old native white male was first admitted to the Grace Hospital Wards on October 27, 1935. Four days previously he had had a sudden onset of dull pain in the right flank. This gradually increased in severity and radiated downward. It was aggravated when the upright position was assumed. There were no gastro-intestinal, genito-urinary or cardio-respiratory symptoms. Past history revealed the usual childhood diseases and early tonsillectomy. It also included a childhood attack of pneumonia and questionable attacks of scarlet and rheumatic fevers. The family and systemic histories were entirely negative.

The important findings on physical examination were a moderately enlarged heart with an accentuated second aortic sound, blood pressure of 210/140 (both arms), and deep tenderness of the right abdomen, both near the iliac crest and over the right upper quadrant. No organ edges were palpable. Murphy's kidney punch test was positive on the right.

Cystoscopy and catheterization of the ureters was readily accomplished. The flow from both sides was somewhat cloudy and diminished. The appearance of indigo carmine following its injection showed a moderate impairment of function bilaterally, more on the right. Open x-rays and other films, after 15 cc. of skiodan were injected into the pelvis of the right kidney, were made at the time of cystoscopy. Later diodrast pyelograms were also made.

The x-rays revealed that both kidneys were enlarged, their outlines not well defined. The calyces were faintly outlined, the central calyx on the right being entirely lost. A large cyst like area, the lining of which seemed covered with a small amount of diodrast, was seen immediately in front of the right transverse process of the second lumbar vertebra. To the left of the twelfth dorsal vertebra was a large cyst like area measuring approximately 6 x 4 cm.

There were no evidences of calculi. The ureters and bladder were clear. The films were interpreted as resembling bilateral cystic kidneys with marked deformity of the calyces.

Laboratory studies revealed that the red count and hemoglobin were normal. The white count was 18,800 with 84% of polymorphonuclears. The urine concentrated up to 1.020, showed a moderate amount of albumin, frequent white cells, some in clumps. There were also frequent red cells and a few hyaline casts. Specimens collected from both sides at cystoscopy showed numerous red and white cells. Phenolsulphonephthalein excretion was 60% in three hours. The nonprotein nitrogen was 45 mg.%. Daily urinary output was excellent. Urine cultures from each side showed a growth of staphylococcus aureus. Wassermann and Kahn were negative. Highest recorded temperature was 100.4°; pulse and respiration rates were normal.

The patient's pain gradually receded. On November 4, when he was discharged (with a diagnosis of polycystic kidneys), he was comfortable and offered no complaints. Shortly afterwards he returned to his work as a corset cutter and remained in apparent good health until April 1936.

The patient entered the New Haven Hospital on May 11, 1936. About one month before admission he had become bedridden. This was chiefly because of muscle tenderness and pain in the arms and legs. No history of pork-eating. Skin test for trichinella spiralis was negative. Other important clinical findings were an apical systolic murmur, occasional gallop rhythm, an enlarged heart and blood pressure of 190/130. The urine showed 2 to 3 red cells and 5 to 6 white cells to each high power field. The phenolsulphonephthalein excretion was 32% in two hours. After admission painful joints developed and there was fever. His discharge diagnosis on June 6, 1936 was acute rheumatic fever, arthritis of acute rheumatic fever, and rheumatic heart disease with acute rheumatic myocarditis.

Following discharge the patient limited his activity to part time work for a period of four or five

weeks. He had no great discomfort except occasional dull backaches. He was admitted to the New Haven Hospital again on September 11, 1936. He gave a history of having been confined to bed following a stabbing pain in the back on September 5. Later there was knife like pain in the right flank. Examination revealed the urinary sediment essentially normal. There was moderate albuminuria. On physical examination there was a mass about the size of an orange in the right upper abdominal quadrant just below the costal margin. On the left side one could palpate what seemed to be the lower pole of the kidney. Additional x-ray studies were performed. In the open films there were evidences of irregular calcification suggestive of calcified cysts overlying the kidney regions bilaterally. The largest of these shadows measured about 5 cm. in the left upper abdomen. The apparent contour of the right kidney suggested lobulation. Pyelograms were also made. On the right side filling was unsatisfactory. The renal pelvis was dilated and the deposition of calcium was thought to be, in part, within the kidney substance. On the left there was good filling of the renal pelvis with medial displacement and distortion of the middle major calyx and its minor calyces. Other minor calyces also showed blunting and dilatation, but those in the inferior portion of the kidney were normal. It was felt that the renal appearance warranted a diagnosis of bilateral polycystic kidneys. The exact site of the annular calcified shadow in the left upper abdomen could not be determined. At the time of discharge on September 16, 1936 the diagnosis was recorded as congenital polycystic kidneys and rheumatic heart disease with mitral involvement.

The fourth and last admission of this patient was at Grace Hospital on March 6, 1940. He had been getting along fairly well except for frequent headaches and an almost constant backache. Two days before admission, while at work, there was an onset of severe abdominal pain which gradually shifted to the right flank and persisted. There was also a dull ache in the left flank. Nausea and vomiting were present. The chief findings on examination were a right internal strabismus, a large heart, a rightsided knobby abdominal mass and a smaller but similar mass on the left. These masses were relatively nontender. The blood pressure was 214/140; nonprotein nitrogen was 33 mg.% and blood sugar 100; other laboratory results were very much as in 1936. On March 9 the patient was found cyanotic and

breathing with great difficulty at a very slow rate (5 per minute). The pupils were widely dilated and non reactive. Blood pressure was 58/40. Oxygen, artificial respiration, and other therapeutic measures were unavailing. The patient died in about an hour. Clinical Diagnoses: Polycystic kidneys, Hypertension, Cerebral Hemorrhage.

Autopsy—(Performed and demonstrated by Doctor Ralph Nichols. Microscopic sections examined by Doctor C. J. Bartlett). The immediate cause of death was found within the skull. The brain was markedly congested and the entire base covered with fresh clotted blood. There was blood in the right ventricle and in the substance of the left frontal lobe. A clot filled the aqueduct of Sylvius and extended posteriorly into the fourth ventricle. Subarachnoid bleeding and other evidences of hemorrhage were noted, but no evidence of aneurysm was found. The heart was very large, weighing 680 grams. The valves were comparatively normal in size and texture. There was marked hypertrophy of the left ventricle. After removing the intestines, exploration revealed that each kidney area was enlarged and contained irregular, very firm nodular masses. Other nodular masses extended across the spine from one superior pole to the other. The celiac axis was patent. Immediately beyond the point of its division the gastric and splenic arteries were found to contain large sacculated, partly organized, multiple aneurysms. That on the gastric side was about 5 cm. in diameter and was about one third filled with organized blood clot. There were four or five aneurysms of the splenic artery, their diameters varying in size from 1 cm. to 3 by 5 cm. On dissection the left renal artery was patent for about 1 cm. It then was transformed into several small sacculated aneurysms and finally continued into a large aneurysm extending completely through the cortex of the kidney and containing a considerable amount of organized blood clot in its wall. The central portion of the kidney was much scarred and presented adjacent atrophy of renal tissue. Further sectioning of the left kidney revealed, in addition to the large aneurysm, numerous small calcified sacculated aneurysms bulging into the calyces. Some of these contained completely organized tissue. The calyces themselves were markedly distorted, but the pelvis and the ureter appeared normal. On the right side the renal artery was completely occluded a few mm. beyond its aortic opening. It was then traced to a large firm mass whose

measurements were roughly 7 by 6 by 5 cm. This mass showed calcium deposits in its wall. It was located practically at the pelvis of the right kidney. On opening it was found to be filled with organized blood clot. Section of the right kidney revealed an upper half almost completely occupied by two large aneurysms filled with organized tissue. The upper one measured about 4 cm. in diameter and the lower 3 cm. Some remnants of cortical tissue were found about these masses. The lower pole of the kidney showed comparatively normal renal cortex. On this side also the renal calyces were markedly distorted, but the pelvis was not dilated. It and the ureter appeared normal. Dissection of the superior mesenteric artery revealed that the lower part of its length in the mesentery traversed numerous small sacculated aneurysms. These varied in diameter from $\frac{1}{2}$ to $1\frac{1}{2}$ cm. Most of them contained considerable calcium in their walls. This calcium deposit extended into the mesentery itself.

DISCUSSION

Chairman: Doctor Bartlett, will you please report on the microscopic examination. Will you also give us your opinion as to the etiology of these aneurysms. Are they congenital?

Doctor C. J. Barlett: The microscopic examination added nothing to the gross description. As far as I can recall this case is unique. I have never seen one like it before and I am unable to state the etiology.

Doctor William Dobbs: Perhaps I should have been more hesitant in leaning toward a diagnosis of polycystic kidneys. Polycystic kidneys are rarely, if ever, calcified.

The International College of Surgeons will hold its fourth international assembly in Mexico City, August 10 to 14, upon the invitation of the Mexican government. Surgeons from most of the countries of the Western hemisphere and also England, Holland, Palestine, Portugal, Switzerland and Turkey will participate. Many of the Pan-American countries are sending official representatives. Sessions will be conducted in both English and Spanish.

Connecticut Tuberculosis Commission Publishes Report

An official public document, the recent report of the State Tuberculosis Commission departs from the customary style by a striking graph on the cover which depicts the decline in the tuberculosis death rate in Connecticut since 1880. Public health workers will also be interested in the chart which indicates the sanatorium districts, and the data pertaining to these districts, as well as the report on the newer phases of the Commission's program in Case-finding.

Barbiturates Limited to Prescription

The Taft Pharmacy in New Haven has announced the voluntary restriction of the sale of the following preparations to prescription only:

Barbiturates of all types, and their derivatives, including barbital, phenobarbital, seconal, amytal, nembutal, and allonal;

Thyroid tablets and preparations.

This policy has been adopted because this pharmacy believes that drugs of this type should be used only under the care of a physician.

The Taft Pharmacy is to be congratulated on this progressive step.

The Ancient and Honorable General Practitioners Section

The *North Carolina Medical Journal*,* after reading the letter by Doctor Herman S. Cutler in our April number, courteously reminds us and at the same time the New York State Journal of Medicine that a general practitioners section was organized in the Medical Society of the State of North Carolina in 1937. It is reported to have had the largest attendance of any section in that Society. We apologize for this oversight and give due credit to North Carolina. Medical Society of the State of New York take notice!

*Edit., May 1941.

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STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

SWIMMING PLACES AND PUBLIC HEALTH

WARREN J. SCOTT, S.B., *Hartford*

There is much conflicting information disseminated about swimming pools and bathing places and their effect on the public health. Many statements on the subject are made without any basis of factual support.

A discussion of possible disease transmission by bathing water might be divided into (1) diseases spread from infection of the water by extraneous sources such as sewage pollution, (2) diseases caused by spread of infection of the water by bathers or (3) afflictions alleged to be due to treatment of water in swimming pools by chemicals. Another distinction might be made as to types of diseases: whether eye, ear, nose, and throat infections; skin infections such as ringworm, eczema, scabies, etc.; venereal infections; or gastro-intestinal disorders.

The Joint Committee on Bathing Places of the American Public Health Association and Conference of State Sanitary Engineers is composed of sanitary engineers with laboratory and medical advisers. This committee has made surveys through questionnaires to state, county and municipal health departments to endeavor to establish authentic data as to spread of infections by bathing places. The surveys have revealed surprisingly little data to indict bathing places in the spread of diseases (1940 report of Joint Committee) despite the potential dangers.

It is unfortunately a fact that little is known as to the exact manner of spread of many skin infections—whether the infection is spread by the use of bathing place appurtenances such as walkways, common towels, suits, or drinking cups, or by other contacts such as might occur on a public playground, or whether the water has acted simply as a vehicle of transmission of disease germs from one bather to another, or whether the infection has been from bodily excretions present in the water. In some of the central states an infection known as “Schistosoma dermatitis” or “swimmer’s itch” has afflicted bathers

in the waters of lakes, ponds and streams where the cercariae, the free swimming larval stage of certain parasitic worms of the family Schistosomatidea have caused the infection, the snails serving as an intermediate host. This type of infection has not been reported in the eastern states, to the writer’s knowledge. Chemical treatment of the water has been effective in control. The writer knows of no published data to indicate that venereal infections have been spread at bathing places.

Eye, ear, nose and throat infections are reported. The Joint Committee states: “Some of these might be due to lowering of resistance from chills; water may wash away protective mucous discharges containing antibodies, leaving the affected parts susceptible; harmful organisms already present in the body may be washed further into the ear and nasal passages during bathing; or excessive amounts of chemicals used for water purification may cause inflammation of mucous membrane and irritation of the skin. These are all possibilities aside from any harmful infections in the water.” Doctor H. Marshall Taylor in the *Journal of the American Medical Association*, September 2, 1939, discusses “Otitis and Sinusitis in the Swimmer.” He points out that the anatomy of the human body is not well adapted to an aquatic environment and describes the danger of ailments to swimmers regardless of any infection or condition of the water.

Authentic reports of gastro-intestinal disorders from swimming pools and bathing places are rare. Perhaps this is due to the fact that bathers drink comparatively small amounts of bathing water as contrasted with conditions on a public drinking water supply. Yet we know that bathing in polluted water is potentially dangerous.

Recent reported recovery of the virus of poliomyelitis by Trask, Vignec and Paul, from the stools of an infant following an illness from abortive polio-

myelitis has posed a startling question for epidemiologists as to whether bathing places might be responsible for the spread of this dread disease. Ellsworth in the *New England Journal of Medicine* (January 11, 1940) points to highest reported occurrence of infantile paralysis during Massachusetts epidemics among communities along the sea coast or along rivers polluted by sewage and also to occurrence during the summer months when bathing is prevalent but he admits that contacts rather than sewage pollution may be responsible. This question must have much further study before any definite conclusions can be drawn. It is of interest that no published data known to the writer have indicated whether any known biological or chemical processes of sewage treatment would be effective in destroying the virus of poliomyelitis.

BACTERIAL STANDARDS FOR BATHING PLACES

It has been possible in the case of swimming pools equipped with recirculation, filtration and disinfection systems, such as exist in many Y. M. C. A. and similar buildings and to an increasing extent in public parks, to develop methods of treatment that will practically eliminate coliform types of bacteria. Therefore, standards of permissible coliform bacteria content for such pools have been established in the Connecticut sanitary code. Streptococci in these pools are difficult to eliminate with heavy bathing loads and no standard limits for their presence have been set up. Usually the initial source of bathing water at controlled pools is a municipal or other safe supply. Treatment offsets contamination introduced by bathers.

With outdoor bathing places, there are always some coliform bacteria present. Also, the bathers themselves introduce contamination. Pollution of bathing water by urination is common. When we consider the dearth of information as to spread of disease from outdoor bathing places it is obvious that there is little justification for condemnation of such waters on the basis of some very arbitrary bacterial standard. Effects of wind, tide, temperature, rainfall and run-off and other factors will influence bacteriological tests. The Joint Committee suggest that in the light of evidence it appears reasonable to conclude that subject to the interpretation of analysis results from all angles, waters which contain less than 1000 coliform organisms per 100 c.c. are fairly acceptable for bathing. This rules out grossly polluted waters.

SUPERVISION OF SWIMMING POOLS

Mention has been made of the standards in the Connecticut state sanitary code which apply to indoor swimming pools and outdoor artificial pools with recirculation systems. The sanitary engineers of the state department of health coöperate with local health officers in inspecting these pools. During the course of inspections, tests are made to determine the effectiveness of disinfection, clarity of the water and filtering processes are checked, review is made of preventive measures such as proper cleanliness and use of foot baths to help guard against foot infections, and samples are collected for analysis. Many of the city health departments regularly sample indoor swimming pools and examine these samples in their own laboratories. In general, it is felt that the quality of pool waters in the state is good. Occasionally complaints come from individuals as to irritation from chlorine. It is impossible to dispense with disinfection and to date chlorine has been found the most effective disinfectant in that its action is rapid and its strength can be readily measured at any time by tests of the pool water. Sometimes the cause of complaints may be an acid condition of the water due to use of chemical coagulants. Some individuals are undoubtedly more susceptible to chemical irritation than others.

THE OLD SWIMMING HOLE

Like such attractive memories as the old oaken bucket type of well, many old swimming holes are now considered insanitary. Some of them are located in the backwaters of polluted streams. Others have very little tributary flow in dry weather. It is usually considered that dilution is necessary to the extent of at least 500 gallons per bather per day. The trend is toward the abandonment of many of these "swimming holes" and the construction of concrete outdoor pools equipped with recirculation, filtration and disinfection systems, where bacteriological conditions can be controlled. Hartford, West Hartford and East Hartford have built such pools and the growth in number in these communities testifies to their success. Plans for new swimming pools with recirculation and treatment systems must be approved by the state department of health according to the state sanitary code.

Where new public bathing pools are to be created by damming up streams, the state sanitary code provides that the locations must be approved by the local health officers.

THE OUTDOOR BATHING PLACE

The Connecticut state department of health several years ago made a complete survey of Connecticut shore waters from East Portchester to Pawcatuck. Samples for analysis were collected on four stages of the tide at points spaced about 500 to 1000 feet apart in two to six feet depth of water. Individual sewer outlets have been located and mapped for the entire Connecticut shore. On the basis of these surveys and analyses, the shore areas have been classed into four groups: Classes A, B, C and D. Information as to classifications has been furnished to the health officers of all towns along the shore. Class D areas are generally banned, and effort is constantly being made to improve the Class B and C areas. In the past few years many sewage treatment plants have been constructed along our shore and plans for others are under way. Financing of improvements has been the chief obstacle.

Most of our lakes in Connecticut are known to be free from serious sources of pollution and offer unexcelled recreational attractions. While some of our rivers are of reasonably good sanitary quality, others like the Connecticut and Naugatuck receive so much pollution that their use for bathing cannot be recommended, despite progress in sewage treatment on some watersheds.

The state is constantly pushing forward with a program to improve the sanitary condition of our waters and individuals can help by doing their part in promoting interest in their respective communities.

Trailer Camps

If basic precautions in sanitation are observed, trailer camps may offer one solution to defense housing difficulties. However, any deviation from cleanliness, pure water supply and proper sewage disposal facilities will result in open invitation to substandard living conditions, ill health and disease. The State of Connecticut has set up in the Sanitary Code certain minimum requirements for trailer

coaches and camp sites. Several towns have adopted ordinances with additional restrictions which include zoning requirements. Other towns might well consider the adoption of control measures, as the problem is certain to increase along with expanding industrial activity.

Conn. Health Bull., May 1941.

One Year Old

The young and flourishing Connecticut Tuberculosis Association has published its first annual report, mimeographed on green paper and attractively bound with a cover showing red type on a deeper tone green. The report informs us that an all time high of \$140,659.00 was realized from the last Christmas Seal sale, that the health education program for the year reached nearly 27,000 individuals with tuberculosis movie films, and that the Rehabilitation Service has provided vocational adjustment to a large number of patients. The *Journal* is commended for courtesies extended the Association by publishing certain articles and notices. The officers and directors of this organization deserve considerable credit for producing such a healthy, growing infant.

Basic Science Bill Killed in Tennessee

The Basic Science Bill in Tennessee, after being passed by both House and Senate, was vetoed by Governor Cooper. The bill lay on the Governor's desk without action until the last hours of the last session of the legislature. When the veto message was sent up to the legislature it was too late for action. The Governor's excuse for exercising his power of veto was that this bill sought to eliminate competition for the doctors. It really was the result of a campaign organized by chiropractors outside of the state in order that their inferior graduates not qualified with a knowledge of the basic sciences might continue to practice in Tennessee.

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cians. We shall be glad to know the name of the sender in every instance.
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EDITORIALS

Quo Vadis?

"To-morrow, and to-morrow, and to-morrow,
Creeps in this petty pace from day to day
To the last syllable of recorded time,
And all our yesterdays have lighted fools
The way to dusty death."*

In the light of the present world aflame and in war torn anguish these words of the poet become prophetic. The past quarter century has known fully the bitter dregs of war and its aftermath and succeeding to-morrows will undoubtedly be no less palatable. Nevertheless, in reviewing the five years 1936-1941 since the *Journal* has been fulfilling its mission of purveyor of information to the Connecticut State Medical Society, there have been put in motion beneficent forces which have had unprecedented influence on the national and individual life.

Consider, if you will, some of the steps which have lifted our Society from what might easily have been an isolation of smugness and self satisfaction to its present position of progress. Prepaid hospital insurance has become a reality and, due to the keen

insight of our Council, an asset to medical practice. Careful study of the possibilities of prepaid medical service is being made by our committee. A Public Relations Committee with a speakers' bureau has been developed. At present compulsory health—or sickness—insurance is not in force, but we are wide awake to that eventuality and are at all times ready to discuss with Labor and Capital any program which shall offer better quality rather than quantity of medical care. Invaluable to our Society has been the appointment of a full time Executive Secretary whose familiarity with the events in Washington and Chicago has been no less than in our own capitol.

The membership of the Society has increased from 1580 to 1825, notwithstanding loss by many deaths and in spite of the increased financial tax. We shall need this increase in numbers to meet the challenge hurled at us by the vital need of medical preparedness. The fact that already plans have been put in motion to this end during the past year may be news to some, or may have been casually brushed aside for the moment. Indifference to the forces of the current will be disastrous to the physician, be he isolationist or strong for all out aid to Britain. That

*Shakespeare: Macbeth, Act V, Sc. V.

the armed men of this country will increasingly require medical aid is self evident. Industry and its attendant housing problems is another phase of defense requiring medical assistance.

With the swift moving events of these uncertain days there can be no assurance that the practice of medicine will remain unchanged. Every American physician will be called upon to take his part in the effort to preserve the American way of life and to redouble his zeal in contributing the best at his command to his chosen profession.

"I do not know beneath what sky
Nor on what seas shall be thy fate;
I only know it shall be high,
I only know it shall be great."*

Certification Under Fire

The "effort to certify specialists is the greatest protection for the public and for the general practitioner as well."† Beginning with the formation of the American Board of Ophthalmic Examinations in 1916, there followed certifying boards functioning for all the major branches of medicine, as well as many representing subsidiary branches and responsible to the parent group. Thus in a quarter of a century has developed one of the most progressive steps in American Medicine, one which still, if properly guided, should become a valuable asset to physician and patient alike. To label the reception of this innovation as unanimously one of approval would be to overlook many of the obstacles that have been surmounted and to fail to recognize new difficulties and dangers that are arising from year to year.

In 1913 when the American College of Surgeons was founded it was thought and hoped that this new organization would determine the proper qualifications of a surgeon and apply them. Because the College believed that the standardization of surgeons necessitated first the standardization of hospitals in order to provide proper training for surgeons, it set itself the task of surveying and grading American hospitals. From this assignment it has never seemed to have emerged and unfortunately its accomplishments have fallen far short of the objective.

The initiative for a correlation of the certifying boards was taken in 1933 by the American Medical Association at its annual meeting in Milwaukee. The following year the Advisory Board of Medical Specialties was formed and at that time it is noted

that the American Medical Association decided that the Advisory Board should work in coöperation with and to a certain extent under the guidance of its own Council on Medical Education and Hospitals. To many it has seemed, and possibly with some justification, that the American Medical Association has not maintained the control expected of a parent over a rapidly growing child. Note the resolution introduced at the last session of the American Medical Association in Cleveland this June* in which attention is called to the lack of recognition given many specialists for years of experience to the request for a careful study of the situation by the American Medical Association to "remove this potential source of dissension in the ranks of American medicine." This resolution is now with the Board of Trustees which promises to "study the records, develop all the facts by proper conferences, in coöperation with the Council on Medical Education and Hospitals and the Specialty Boards, and will try to work out a plan for presentation later to the House."***

The danger signal is on. The boards are entirely voluntary and their activities supported by fees of candidates. The only control exercised over them is a supervisory one by their own Advisory Board and by the Council on Medical Education and Hospitals. Doctor Howard T. Karsner, Professor of Pathology at Western Reserve School of Medicine, has put it very plainly: "Admirable as is this independence, it carries with it the hazard of dogmatic decisions and autocratic operation."*** Formation of labor unions within the profession threaten but we agree entirely with Doctor Karsner that the labor union has no share in the medical profession. It has been proposed that hospitals accept on their staffs only those certified by the boards. The Federal Government through its agencies is arbitrarily using certification by specialty boards as an imperative requirement for performance of many medical services paid for by government funds. In one instance the certificate of the American Board of Orthopedic Surgery has been made a prerequisite for eligibility for appointment in the forwarding of a state program. All of these developments spell autocracy and if persisted in will defeat the purpose of the entire plan of certification which is and should remain voluntary. There must be no pressure

*J. A. M. A. 116, 2700, June 14, 1941.

**J. A. M. A. 116, 2794, June 14, 1941.

***J. A. M. A. 117, 1, July 5, 1941.

*Richard Hovey: Manifest Destiny.

†Fling, Conn. State Med. Jour. II, 6, Jan. 1938.

exerted from without to force certification upon any graduate of medicine. Within the voluntary feature lies the strength of the whole program. It is a worthwhile venture and deserves to be fostered by the profession and in particular by its parent organization, the American Medical Association. We look to the Board of Trustees for wise and judicious guidance.

Causes of Death in Connecticut

Pneumonia is no longer the "Captain of the Man of Death" as Sir William Osler once said. Mortality statistics for the year 1940 recently made public by the State Department of Health disclose, as has been the case for many years, that cancer is the greatest cause of deaths in Connecticut. There were 17,555 deaths last year, 2,562 or 15 per cent resulted from cancer, a rate of 149.7 per 100,000 of population, the highest cancer death rate in the State's history.

Diseases of the heart and arteries accounted for the second largest number. Pneumonia took 692 lives and tuberculosis 525. There were 1,032 accidental deaths and 310 suicides.

The general death rate for the State per 1,000 population increased from 9.6 in 1939 to 10.3 in 1940. The birth rate per 1,000 population was increased from 12.8 to 14.3.

There were 24,487 living births recorded during the year with only 847 deaths during first year of life. The infant mortality rate of 34.6 per 1,000 live births was the lowest ever recorded and may be the lowest in the nation. There were 68 maternal deaths.

The striking changes in the mortality rates that have been brought about by public health measures and the control of infectious diseases is evidenced by these figures: typhoid fever, five deaths; measles, four; whooping cough, five; diphtheria, three; poliomyelitis, two; meningitis, six.

Based upon its mortality statistics Connecticut continues to be one of the healthiest states in the union.

Liquor and Hats

In 1939 the United States National Safety Congress reported that a blood volume above 0.15 per cent alcohol should be considered as evidence that the driver is under the influence of alcohol, a stand so strict that it was soon modified. At the other extreme we find a certain judge in New London only a few weeks ago acquitting a woman charged with operating an automobile while under the influence

of liquor, on the ground that she was not under the influence of liquor at the time of the collision *but that the liquor she had consumed took effect after she had been arrested and locked up at the police station.**

The menace from intoxicated drivers at the wheel grows no less with each passing year. Attempts have been made to devise foolproof tests indicating the presence or absence of alcoholism, but as yet these have not been too successful. That there is extensive drinking among motorists was proven some time ago by the New York State police in surprise tests of the breath of motorists at Mineola. These showed that 58 out of 100 late night and early morning motorists had been drinking.**

Other driving hazards beside alcohol have been enumerated. One of these hazards is said to be produced by women who wear hats partly or almost completely covering one eye.** One might even speculate on the possibility of such a hazard having its effect upon a judge to the extent that he would be unable to determine whether or not the gentle culprit was intoxicated, had been intoxicated, or was about to be intoxicated. Stranger things than hats have upset the course of the law but drunken driving is too serious to be thus winked at.

Rheumatic Fever in Connecticut

The report of A General Survey of Rheumatic Fever in Connecticut and a social survey that has just been published by the State Department of Health is a major contribution to medical knowledge in this State. The epidemiological study was made by Doctor John R. Paul and Doctor Joyce V. Deutsch of the Section on Preventive Medicine of the Yale School of Medicine; the social survey was carried out by Parrish R. Kelley, Mary F. Champlin and Ellen E. Ogren of the Division of Crippled Children, Bureau of Child Hygiene of the Connecticut State Department of Health.

The foreword to the report states that rheumatic fever is a disease that may be classed as the third most common chronic infection after tuberculosis and syphilis, but through the years in spite of the need for wider knowledge of the disease, relatively little public health work has been done in connection with it. The present study, which was part of the Connecticut Plan for Crippled Children's Services for the year 1939-1940, was financed by the

*New London Day.

**Weekly Roster & Med. Dig., Phila., June 28, 1941.

State Department of Health and funds provided by the Children's Bureau of the United States Department of Labor.

The report presents an interesting discussion of the meteorological conditions that affect the incidence of rheumatic fever. Climate appears to be a factor in the prevalence of the disease and the observers state that there is reason to believe that it is common in the New England and Middle Atlantic states and diminishes in frequency toward the southern borders of the country.

Mortality statistics, hospitalization, adequacy of medical care and types of therapy and follow up care are given appropriate consideration. There is a partial resumé of special hospital and dispensary facilities that are available for the care of rheumatic fever and its cardiac sequelae.

The social survey is suggested as a basis for plans that may be made to aid children of Connecticut suffering from rheumatic heart disease whose families are economically unable to meet the cost of private care over long periods. Various areas in the State were selected for the social study, these included agricultural communities, mill towns, industrial centers and one large city. The cases were studied from point of view of their housing, economic status, family environment, the patient himself, leisure time activities and education. The survey concludes that although the study cannot be final, from a statistical point of view it does point to the existence of a need for assistance in the form of funds and service for children with rheumatic heart disease.

The lack of specific diagnostic procedures complicates the full recognition of the existence of rheumatic fever and, as the report says, "the practitioner must resort largely to his wits and his stethoscope." Once diagnosed the treatment of the disease is not altogether satisfactory and there is no method that has gone much beyond the experimental stage which can be recommended as a means of prevention. "All of these things," says the report, "tend to make the public health officer regard rheumatic fever with some dismay." However, if the disease cannot be controlled, it was the purpose of this survey to begin observations on its prevalence, which is surely a logical approach to the solution of a problem that is of increasing economic importance.

Doctor Paul and his associates are to be complimented on the quality and thoroughness with which this study has been made and it is hoped a means

will be provided for the extension of the suggested program.

Doctor Linde Reappointed to Tuberculosis Commission

The law providing for the State Tuberculosis Commission requires that the Commission shall consist of five members, "one of whom shall be a physician who has had at least ten years active practice and is an expert in the modern treatment of human tuberculosis." When the Commission was established more than thirty years ago Doctor Stephen J. Maher was the first physician appointed to membership on it, and during the years that followed Doctor Maher was the activating spirit in the development of the State's highly commendable tuberculosis program. No other physician served on the Commission during that long period and when Doctor Maher died in the summer of 1939 Governor Baldwin realizing the importance of the proper choice of his successor, consulted this Society for suggestions. The Council made recommendations to the Governor and Doctor Joseph I. Linde of New Haven was appointed to serve the unexpired term left vacant by Doctor Maher's death.

Doctor Linde brought to the Commission a somewhat unusual combination of qualifications. He has a long and progressive background of medical practice in the field of pediatrics, has for years been concerned with Visiting Nurse and other similar organizations, and his present experience as Health Officer to the City of New Haven has made him familiar with the public administration of health affairs. In addition to these qualities he has always shown an unselfish willingness to accept public and social responsibility. This last is a valuable attribute for members of the Tuberculosis Commission who must serve without recompense, and the activities of the Commission in maintaining the five state sanatoria with an annual budget of over two millions of dollars take a vast amount of time. The legislature of 1939 made an appropriation to the Commission for the purpose of carrying out the case finding study. Doctor Linde joined the Commission just in time to take over the direction of this important new function of the Commission.

The interim appointment that Doctor Linde held expired on July 1 of this year and it is gratifying to note that Governor Hurley, realizing Doctor Linde's valuable service, has reappointed him as a member of the Commission for a regular term of six years.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

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SURVEY OF BARBITURATE ADDICTION

For some time there has been a discussion of the extent and results of the promiscuous use of the barbiturate derivatives. There are those who believe that addiction to them is becoming a problem of increasing importance. In a few states there are rigid laws regulating the dispensing of these drugs and from time to time it has been suggested that their sale in Connecticut be controlled by statute. A bill to accomplish this was unsuccessfully proposed to the General Assembly of 1939.

The Society's Committee on Drug Addiction is making an effort to determine the extent of the use of these and similar drugs without a physician's advice and the opinion of the physicians in the State in respect to regulation of their sale. There is great general interest in the project on the part of the public as is evidenced by the widespread newspaper publicity that it has received.

The Committee has distributed a brief questionnaire to all members of the Society asking for certain facts as observed by physicians and their opinions. Members of the Society are urged to return the card promptly to Doctor Wagner, the Chairman of the Committee, so that when the report is compiled, it may be fully representative.

Council Recommends Physicians for Examining Board for Physical Therapy Technicians

The General Assembly of 1941 by the passage of House Bill 184 established a State Board of Examiners for Physical Therapy Technicians. Section 7 of the bill provides:

"There shall be a Connecticut state board of examiners for physiotherapy technicians, which shall consist of five members to be appointed by the governor from a list of names submitted by The Connecticut State Medical Society. On or before July 1, 1941, he shall appoint five members of said board, one to serve one year, one to serve two years, one to serve three years, one to serve four years and one to serve five years from said July 1, and annually thereafter he shall appoint one member from the names submitted by The Connecticut State Medical Society, to serve a term of five years from July 1 in the year of appointment. Any vacancy in said board shall be filled by the governor from a list submitted by The Connecticut State Medical Society. Each member shall be a resident of the state, shall be a doctor of medicine and a member of The Connecticut State Medical Society."

In accordance with the above the Council, acting for the State Society, after receiving suggestions

from the Section on Physical Therapy of the Society recommended to the Governor the names of eight members of the Society from whom the Governor might appoint the five members of the Board.

Committee on Public Relations to Have Press Representative

The Council approved a request from the Chairman of the Committee on Public Relations that the Committee might retain a press representative. Mr. Eugene Kone has entered the part time employment of the Committee on Public Relations for the six months period ending January, 1942. He has previously done publicity work for the Society and is familiar with its policies and objectives. Mr. Kone graduated from Yale in June, 1941, and is an Associate in the Department of Public Relations of Yale University.

Committee to Continue Study of Prepaid Medical Service

In accordance with the resolution passed by the House of Delegates the Council has appointed the Committee to continue the study of prepaid medical service and to make recommendations to the House of Delegates. The members of the Committee are:

Chairman, Oliver L. Stringfield, Stamford; Samuel C. Harvey, New Haven; James R. Miller, Hartford; Thomas P. Murdock, Meriden; Benedict N. Whipple, Bristol; Morris P. Pitcock, Fairfield.

Employment Openings for Physicians

This office is receiving an increasing number of inquiries and information concerning employment opportunities for physicians. There are many vacancies available in the State employ which are becoming difficult to fill. Requests are frequently made for physicians for full time positions in industry and some physicians are asking assistance or a locum tenens for the period of military service.

If any members of the Society are interested in further information concerning these openings or if they have knowledge of young physicians who are seeking locations, the Secretary will be glad to confer with them.

The 1941 Roster

The 1941 roster of membership in the Society is published elsewhere in this issue. It includes the largest number of names that has ever been published in an annual roster. Names, initials, street addresses, and years of graduation have been carefully checked with available data. It is unavoidable for minor errors to occur and it is possible that the information in the Secretary's office is not accurate. The Secretary will appreciate notations of corrections from members.

Conference on Revision of By-Laws

The By-Law Revision Committee under the Chairmanship of Doctor D. Chester Brown, met in conference with county secretaries and officers of the State Society on June 17. There were present from the Committee: D. Chester Brown, Charles G. Barnum, William Shepard, Thacher W. Worthen; James D. Gold, President of the Society, the Executive Secretary and J. Grady Booe, Fairfield County; Clifton C. Taylor, Fairfield County; Frank T. Oberg, Hartford County; Charles Russman, Middlesex County; Ralph E. McDonnell, New Haven

County; Thomas Soltz, New London County; Ralph L. Gilman, Windham County.

In the revision of the By-Laws of the State Society it is the purpose of the Committee to eliminate inconsistencies that exist between the By-Laws of the State Society and the county associations, and to establish a uniformity of procedures among the county associations insofar as such practice does not interfere with the autonomy of the county associations. Particular attention will be given to uniformity of the requirements for membership in the various associations and a simplification of the procedure of transfer from one county association to another.

Invitations to Associate Membership

Acting under the amendment to the By-Laws passed by the House of Delegates in May the Council has authorized the Secretary to invite a small number of distinguished persons interested in public health and medical sciences to become associate members of the Society.

Registration for Clinical Congress

Registrations for the 1941 Clinical Congress are being received in the Secretary's office and the outlook is good for the usual large attendance. Doctor William J. Bruckner of New Haven has been added to the Committee on Publicity and Registration of the Congress.

American Medical Association 1942

The annual convention of the American Medical Association will be held in Atlantic City June 8-12, 1942.

THE DOCTOR'S OFFICE

Edward H. Truex, M.D., announces the opening of his office on July 1 for the Practice of Ear, Nose and Throat at 99 Pratt Street, Hartford. Office hours by appointment.

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GRACE HOSPITAL DIET MANUAL

Special Diet Lists

The following Dietary Manual was prepared for use at Grace Hospital by the chief dietician, Miss Dorothy Milavetz. In the preparation of this manual, members of the Staff were called in consultation. It is submitted in the Journal with the thought that it might be helpful to other institutions.

CLEAR WARM LIQUID

Tea, black coffee, broth, bouillon.

CLEAR LIQUIDS (without milk)

Tea, black coffee, postum, fruit juices, strained fruit ades, carbonated beverages, broth, bouillon, cereal waters, beef juice, strained vegetable juices, fruit ices, jello, albumin water.

LIQUIDS WITH MILK

All liquids stated above plus milk, cream, malted milk, cereal gruel, egg lemonade, cream soups, cocoa, smooth ice cream.

Sample menu as served from the kitchens

(In between nourishment served from floor pantries)

BREAKFAST: Orange juice; Oatmeal gruel with cream; Coffee with cream.

DINNER: Strained soup stock; Vanilla ice cream; Tea with cream.

SUPPER: Strained cream soup; Jello; Tea with cream.

HIGH CALORIC LIQUIDS

Will include all liquid diets reinforced with extra cream and with lactose.

This diet is dependent upon the needs of the patient, i.e. tooth extraction, Jaw fracture.

BREAKFAST: 8 ounces orange juice with 1 tablespoon lactose; Strained farina gruel with cream; 8 ounces egg nog; Coffee; 2 ounces cream.

DINNER: Strained soup stock; 8 ounces pineapple juice with 1 tablespoon lactose; Vanilla ice cream; Tea; 2 ounces cream.

SUPPER: Strained cream soup; 8 ounces chocolate milk with 2 ounces cream; Jello; Tea; 2 ounces cream.

SEMI-SOFT DIET

Will include all liquids plus: 1. Toast; 2. Butter; 3. Custard; 4. Soft cooked or poached egg.

SELECTED SOFT DIET

No ice water allowed on the tray.

BREAKFAST: Fruit puree; Cereal with cream; Toast; Butter; Coffee.

DINNER: Milk toast; Toast; Butter; Jello; Tea with cream.

SUPPER: Minced chicken in broth; Toast; Butter; Custard; Tea; Cream.

SOFT DIET

FOODS ALLOWED:

All liquids.

Puree of dried fruits, stewed soft fruit without skin (i.e. peaches, peeled apricots, pears, apple sauce), jelly.

Cereals: Cornmeal, cream of wheat farina, oatmeal, wheatena, dry cereals except branflakes.

Breads: white bread, toast (buttered, creamed, or with milk), white crackers.

Eggs: Any way but fried.

Meat or substitutes: chicken or turkey, bacon, fresh flaked fish, cottage cheese, sweetbreads, cream cheese, broiled chicken livers.

Potato: Mashed, baked, creamed, or riced.

Potato substitute: Macaroni, spaghetti, rice, noodles.

Vegetables: Puree of beet, carrot, peas, spinach, squash, string beans; strained tomato, asparagus tips.

Desserts: Jello, custard, junket, fruit whips. Puddings: bread, cornstarch, cream, rice without raisins, tapioca; ice cream and sherbets without fruit or nuts, sponge cake.

The estimated average caloric content of this diet as served in the Private Pavilion is 2000 calories, made up of protein 60 grams, fat 100 grams, carbohydrate 225 grams.

The estimated average caloric content of this diet as served in the Ward Building is 1700 calories, to be made up of protein 60 grams, fat 80 grams, and carbohydrate 190 grams.

SOFT HIGH CALORIC DIET

Soft diet plus: 1. Extra cream; 2. Extra butter;
2. High caloric liquids.

SOFT HIGH CARBOHYDRATE DIET

Soft diet plus: 1. Jelly; 2. Fruit juice reinforced
with lactose.

LIGHT DIET

The light diet will consist of all foods on the soft
diet plus:

1. Whole cooked vegetables (omit coarse or
strong vegetables).
2. Lettuce hearts, celery hearts, peeled tomatoes.
3. Whole cooked fruits except pineapple.
4. Fresh oranges, grapefruit, ripe bananas.
5. Broiled, roast, or baked meats.
6. Broiled fish.
7. A simple cake or cookie added to the soft
desserts.

MECHANICAL SOFT DIET

A mechanical soft diet is a diet requiring little or
no mastication, and one which will be easily swal-
lowed. There are no restrictions on the type of food
used, only in its consistency.

REGULAR DIET

A general diet which adequately provides for the
body needs.

The estimated average caloric content of this diet
as served in the Private Pavilion is 3200 calories,
made up of protein 100 grams, fat 175 grams, and
carbohydrate 300 grams.

The estimated average caloric content of this diet
as served in the wards is 2400 calories, made up of
protein 90 grams, fat 125 grams, and carbohydrates
225 grams.

HIGH CALORIC REGULAR DIET

A regular diet reinforced with: 1. Extra cream;
2. Extra butter.

**HIGH CALORIC HIGH VITAMIN REGULAR
DIET**

A regular diet plus: 1. Extra butter; 2. Extra cream;
3. Orange juice, tomato juice, and grapefruit juice
in season.

HIGH CARBOHYDRATE REGULAR DIET

A regular diet plus: 1. Jelly; 2. Fruit juice rein-
forced with lactose.

**REGULAR DIET WITHOUT STIMULANTS
(no condiments)**

A regular diet without tea, coffee, meat soups,
gravies, salad dressings, vinegar, salt, and pepper.

**HIGH ROUGHAGE OR HIGH RESIDUE
DIET**

A regular diet reinforced with bran and extra fruits
and vegetables.

LOW RESIDUE OR LOW ROUGHAGE DIET

This diet will consist of foodstuffs which will leave
a small residue and therefore leave a minimum
amount of bulk in the feces.

*Sample Menus***SOFT LOW RESIDUE**

BREAKFAST: Strained orange juice; Farina, cream;
Toast, butter; Soft cooked egg; Coffee.

DINNER: Strained Soup, Mashed Potatoes; Pea
Puree; Peach Puree; Bread and Butter; Tea with
Cream.

SUPPER: Strained Soup; Poached Egg on Toast;
Baked Potato; Junket; Bread and Butter; Tea with
Cream.

REGULAR LOW RESIDUE

BREAKFAST: Strained orange juice; Farina, cream;
Toast, Butter; Soft cooked egg; Coffee.

DINNER: Strained Soup; Roast Leg of Lamb; Mashed
Potato; Pea Puree; Peach Puree; Bread and But-
ter; Tea with cream.

SUPPER: Strained Soup; Broiled Hamburger on
Toast; Tomato Juice; Pear Puree; Bread and But-
ter; Tea with Cream.

RESIDUE FREE DIET

Only Dry toast; Boiled milk; Jello; Broth with rice
or noodles; Farina; Milk toast.

LOW CALCIUM DIET

A low calcium diet shall be made up of those
foods which contain a minimum amount of calcium.
These are:

Meat	Rice.	Bananas.
Liver.	Canned corn.	Apples.
Potatoes.	Tomatoes.	Tea.
		Coffee.

Included also are: 1. Salt free bread; 2. Soda bicar-
bonate biscuits; 3. Sugar, salt, and pepper.

HIGH CALCIUM DIET

A high calcium diet consists of a regular diet reinforced by milk, green vegetables, and fruits.

DIABETIC DIET

The prescription must be individual in each case—should also include the kind of diet—regular, soft, liquid.

The glucose in the food refused will be replaced at each meal.

KARRELL DIET

800 cc. of milk (200 cc. given four times daily). After four days increase to 1000 cc. plus toast, cereal, and soft cooked eggs.

ANEMIA DIET

Adequate general diet including foods high in iron and high in vitamins.

HIGH IRON FOODS:

Liver. Molasses. Nuts.
Kidneys. Dried fruits. Fresh peas and lima beans.
Egg yolks. Muscle meats. Whole grain products.

In pernicious anemia: half pound liver daily included plus high iron and high vitamin.

OBESITY DIET

Protein normal.

Carbohydrates will be supplied in foods which will furnish mineral matter, vitamins and bulk.

Fats reduced according to caloric specification. Bulky foods to satisfy hunger.

Unless specified, diet will be approximately 1200 calories for adults.

ULCER MANAGEMENT

FIRST WEEK: Three ounces of milk and cream mixture is taken every hour beginning at 7:00 A. M. Last feeding is at 9:00 P. M.

SECOND WEEK: *In place of milk feeding* at 8:00 A. M. and 6:00 P. M., one of the following may be given:

- 4 ounces cooked cereal (Farina; strained oatmeal, cornmeal).
- 2 ounces cream.
- 6 ounces cream soup without broth (strained).
- 4 ounces cup custard.
- 4 ounces junket.

THIRD WEEK: *A noon feeding is substituted for the 12 o'clock milk and cream feeding.*

The following foods may be added to the list allowed on the second week and three small meals served:

1. Cornstarch pudding, prune whip, blanc mange.
2. Soft cooked egg.
3. Half slice toast, or toasted crackers, butter.
4. Ice Cream occasionally.
5. Strained fruit as prunes or applesauce.

FOURTH WEEK: The following foods are added to the third week list:

1. Vegetable puree such as peas, spinach, asparagus.
2. Baked potato.
3. Pureed baked apple.
4. Plain Jello with whipped cream, rice pudding.
5. Macaroni creamed, spaghetti creamed or buttered.
6. Eggs, soft, poached, baked with cream, scrambled with cream. *No fried eggs.*

AMBULATORY OR CONVALESCENT
ULCER DIET (Bland diet)

An ambulatory ulcer diet or a bland diet is one which is low in sweets, free of acids, meat extractives, and high seasonings. Foods that would be stimulating to the gastric secretions or irritating are excluded.

Note: We recommend the addition of a minimum of 8 ounces of orange juice to this diet.

Specific Restrictions:

1. No tea or coffee.
2. No gravies or meat soups.
3. All vegetables pureed (no tomatoes).
4. All stewed fruits pureed (no apricots).
5. Meats allowed:
Roast meats (no pork or ham).
Chicken livers.
Chicken.
Broiled steaks and chops.
Fresh fish—Broiled, boiled, or baked.
6. No pepper.

Sample Menu

BREAKFAST: Stewed Fruit Puree (no apricot); Farina; Cream or milk; Poached Egg on Toast; Toast; Butter; Glass milk; Salt; Sugar.

DINNER: Pot Roast of beef (well cooked) (no gravy); Mashed Potatoes; Pea Puree; Toast; Butter; Pear Puree; Glass milk; Sugar; Salt.

SUPPER: Cream Soup (vegetable puree plus milk or cream); Soft cooked egg; Baked potato; Toast; Butter; Applesauce; Glass milk; Sugar; Salt.

POST OPERATIVE GASTRIC ULCER DIET

A gradual progression from small amounts of water through, bland, liquids, and soft diets.

Bland, non-irritating foods similar to those used in ulcer diets are given.

A SALT POOR OR LOW SALT DIET

will be interpreted as follows:

1. No salt allowed on patient's tray.
2. A moderate amount of salt will be added in the preparation of the diet where it is necessary for palatability.
3. Foods that are salty—ham and bacon, dressing, gravies, meat soups will be omitted.

Sample Menu (regular)

BREAKFAST: Orange juice; Cereal with cream; Egg; Toast; Butter; Jelly; Coffee; Sugar.

DINNER: 8 ounces pineapple juice; Broiled lamb chops; Mashed potatoes; Buttered peas; Lettuce and Tomato with Lemon; Bread; Butter; Fresh Fruit Cup; Tea; Cream.

SUPPER: Cream soup (no broth); Sliced chicken sandwich; Head Lettuce with Lemon; Bread; Butter; Elberta Peaches; Tea; Cream.

A SALT FREE DIET

will be interpreted as follows:

1. No salt will be used in preparation of food.
2. No salt on the patient's tray.
3. Foods of low salt content used entirely.
4. No milk or foods made with milk.
5. No canned vegetables used.

Sample Menu (regular)

BREAKFAST: Orange juice; Salt free farina; Soft cooked egg; Salt free toasted muffin; Salt free butter; Coffee; Cream.

DINNER: 8 ounces pineapple juice; Salt free mashed potato (with cream); Lettuce and tomato with Lemon; Salt free muffin; Salt free butter; Salt free fresh beets; Fresh fruit cup; Tea; Cream.

SUPPER: Fresh fruit plate; Celery hearts; Baked potato; Salt free butter; Salt free muffin; Apple-sauce; Tea; Cream.

LOW PROTEIN DIET

Should have a maximum of 60 grams of protein per day, and unless specified, should have a minimum of 50 grams of protein per day.

No other restrictions will be placed on this diet unless specified.

Notes: Tea and coffee will be given on this diet unless specified.

Protein included as follows:

- 1 pint milk a day.
- 2 eggs or protein equivalent daily.

PURIN FREE DIET

For disturbance of purin metabolism.

The following *purin rich* foods will be omitted:

Sweetbreads.	Lean pork.
Liver.	Salmon.
Lean beef.	Veal.
Chicken.	Halibut.
Mutton.	Codfish.
Kidney beans.	Tea.
Asparagus.	Cocoa.
Coffee.	Meat soups.
Condiments.	Oatmeal.
Whole grained cereals.	Beans.
Peas.	Lentils.
Turkey.	

TYPHOID DIET

Energy to maintain normal weight, 3000 to 6000 calories. Protein 60-90 grams, abundant fluids, frequent feedings.

Fluids the first few days, gradually progress to soft diet as patient improves.

Important: All liquids are to be strained twice. Feedings every 2 hours.

Any strained fruit juice.	Rice and cream of wheat.
Any strained fruit ice.	Junket.
Any strained broth.	Poached, soft cooked, soft scrambled eggs.
Strained gruel with cream.	Eggnog, cooked or raw.
Cornstarch puddings.	Fruit whips.
Dry toast without crusts.	Strained cream soups.
Soaked toast or crackers.	Cocoa, chocolate.
Dry crisp crackers.	Ice Cream.
Milk or cream toast.	Malted milk.
Milk and cream.	Modified milk mixtures.
Fruit albumins.	Coffee.
Tea.	Custard.

When temperature has been normal 2 days, add:

Baked Potato. Buttered Toast.

When temperature has been normal one week, add:

Scraped beef.	Jellies.
Creamed sweetbreads.	Syrup.
Bacon.	Cornflakes, Rice Krispies
Minced chicken.	or Puffed Rice with cream.
Flaked fish.	

Food value will be increased with lactose unless contraindicated.

CARDIAC DIET

Small meals of easily digested foods.

No sweets or rich desserts.

No strong-flavored vegetables.

A varied normal diet with the above considerations.

Note: Salt and fluids restricted *only* according to specifications.

LOW FAT REGULAR DIET

An adequate diet with the following restrictions:

1. All foods prepared without any additional fat.
2. No butter or cream.
3. Eggs if tolerated.
4. Skimmed milk used.
5. Meat—lean roast meat without gravy; chicken; Broiled fat free lamb chops, steak, ground beef with no added fat in cooking, broiled liver.
6. Fresh fish—broiled, boiled, or baked without fat. *Washed* canned tunafish.
7. No strong-flavored vegetables.

LOW FAT SOFT DIET

1. Same principles as used in low fat regular using foods from soft diet.
2. Turkey, chicken, or chicken liver only meats used. Fish may be used flaked.

FAT FREE REGULAR AND SOFT DIETS

Same instructions as for low fat soft and regular diets with these exceptions:

1. Only white meat of chicken used.
2. Non-fatty fish.

KOSHER DIET

ROUTINE:

1. No meats or meat soups.
2. Occasionally patient will eat white meat of chicken.
3. No lobster, clams, oysters, or crabmeat.

STRICT: *Include only the following foods:*

Soft cooked egg in shell.
Canned fruit.
Fresh fruit.
Fruit juice and tomato juice.
Baked potato in skin.
Milk, tea, coffee.
Unecda biscuits (no bread)
Butter (usually sweet).
Raw vegetables.

This list may be increased if the patient wishes.

T & A DIET

Day of operation

Diet starts at supper.

Only Vanilla ice cream.

Junket or custard.

First Day Post-operative

BREAKFAST: Farina; Prune or pear puree; Bread without crusts; Butter; Coffee; Cream.

DINNER: Poached egg on milk toast (crusts removed); Bread without crusts; Butter; Tea; Cream; Peach puree, custard or Vanilla ice cream.

SUPPER: Same breakfast.

Repeat for second day. Increase foods as tolerated.

KETOGENIC DIET

A high fat diet with low carbohydrate and limited protein. The fatty acid glucose ratio is high enough to produce ketosis. Prescription must be individual in each case. The following is a sample of one type of ketogenic menu:

Approximately

20 grams carbohydrate	240 grams fat
70 grams protein	2500 calories

Food allowance for one day:

3% vegetables—4 servings—2 cups.

Soya bean muffins—3

Butter—10 squares—1/5 pound.

Cream, heavy whipping—1/2 pint—6 1/2 ounces.

Bacon—4 strips.

Eggs—2.

Meat—3 ounces—1/4 lb.—90 grams.

Water, coffee, tea, broth and bouillons are allowed in addition to the above foods.

Saccharine may be used to sweeten tea or coffee.

3% Vegetables

Cucumbers.	Swiss chard.	Cauliflower.
Lettuce.	Celery.	Eggplant.
Spinach.	Dandelion greens.	Cabbage.
Asparagus.	Tomato.	Radishes.
Endive.	Brussel sprouts.	String beans.
Sauerkraut.	Watercress.	Mushrooms.
Beet greens.	Seakale.	

Soya Muffins

Baker's Bran, 3/4 cup.	Soya bean meal, 1/2 cup.
Eggs, 4.	Butter, 2 ounces.
Baking powder,	Salt, 1 teaspoon.
1 level teaspoon.	Water, 3/4 cup.

(Concluded in September, 1941)

MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic
FRANCIS G. BLAKE, Dean Yale School of Medicine New Haven		STANLEY H. OSBORN, State Commissioner of Health Hartford	

GEORGE M. SMITH, M.D., State Chairman, 258 Church Street, New Haven, Conn.

DOCTOR DANIEL SULLIVAN BECOMES CHAIRMAN OF NEW LONDON PREPAREDNESS COMMITTEE

The Mayor of New London has appointed Doctor Daniel Sullivan the Chairman of the New London City Defense Committee. Doctor Sullivan has been the New London County representative on the State Medical Society's Committee on Medical Preparedness since the Committee was established in 1940. During the months that he has occupied that position conspicuous progress has been made in planning and organization in the medical field of preparedness in New London County and his designation as the Chairman of the Mayor's civilian committee is evidence of his recognized ability.

Organization of Medical Preparedness Committee Expanded

On the invitation of the Chairman of the Society's Medical Preparedness Committee, Doctor Francis G. Blake, Dean of the Yale School of Medicine and Doctor Stanley H. Osborn, State Health Commissioner have accepted appointments as members of the Committee.

Advisory committees to the Committee on Preparedness have also been appointed. In Maternal Welfare, Doctor Joseph H. Howard, Doctor James R. Miller, Doctor Martha A. O'Malley. In Child Welfare, Doctor Grover F. Powers, Doctor J. Harold Root, Doctor Martha L. Clifford. In Industrial Medicine, Doctor Andrew J. Jackson, Doctor Paul W. Vestal, Doctor Albert S. Gray.

Medical Students to be Commissioned

Brigadier General Francis B. Wilby, Commanding General of the First Corps Area, has announced that the War Department has granted authority to the United States Army for the commissioning of young men who are in their third or fourth years in accepted medical schools as second lieutenants in the Medical Administrative Reserve. Authority is given also for commissioning internes, who are properly qualified, as first lieutenants in the Medical Corps Reserve, with the purpose that they will be ordered to active duty for one year of extended training upon the completion of their internship.

Deferment of Enrollees Over 28

Instruction recently issued from General Lewis B. Hershey, Acting Director of the Selective Service authorizes local draft boards to defer the enlistment of all enrollees who have reached their 28th birthday. The reasons for this are that experience with the training army during the first ten months of its organization has shown that younger recruits are more suitable for the rigorous course of training that is required. Moreover taking men from the younger age group does not cause the same economic and occupational disturbance as when older enrollees are inducted into the Service.

This new regulation will have a direct and simplifying effect on the medical situation. Not many physicians under 28 have become firmly and necessarily established in community practice and their departure for military service will not disrupt the medical care of the civilian population.

The American Medical Association Medical Preparedness Study

There were approximately 2,600 American Medical Association medical preparedness questionnaires sent to physicians in this state late last summer when the study of the medical personnel was undertaken by the Association. Records in the office of the Secretary of this Society now show that only about 125 Connecticut physicians have not returned these questionnaires. The Society's Committee on

Medical Preparedness decided that one more attempt should be made to urge physicians to return this last small number of information sheets. New questionnaires have been sent from the office of the Secretary to those physicians who have not yet filed and it is hoped that most of them will be returned promptly so that Connecticut's record may be the best possible.

Society's Committee on Preparedness Meets With State Defense Council

Doctor George M. Smith, Chairman of the Committee on Medical Preparedness and a member of the State Defense Council and the Executive Secretary of the Society met with the representatives of the State Defense Council in the office of the Administrator in the State Armory on June 19. Others attending were Colonel Samuel H. Fisher, Administrator, General Sanford H. Wadhams, Mr. Albert W. Buck, Chairman of the Preparedness Committee of the Connecticut Hospital Association, Miss Ida Butler, Chairman of the Preparedness Committee of the Connecticut State Nursing Association, Miss Marion Douglass from the Nurses Association, Miss Anna Griffin of the Hospital Association, Mr. John Andrews of the Planning Division of the State Defense Council.

Consideration was given to the integration of selected hospitals with the State defense plan, provisions for the medical care and housing of evacuees and the training of air raid wardens.

All of the members of the Society's Preparedness Committee met with Colonel Fisher at his invitation in the State Armory in Hartford on June 26. Beside the Society's Committee there were present Colonel Fisher, General Wadhams, Mr. Andrews and Mr. Herbert Gallaudet who is directing the training of air raid wardens.

The general organization of the defense plans was outlined by Colonel Fisher and the air raid wardens training explained by Mr. Gallaudet. Hospital facilities, organization, and emergency expansion were discussed.

A meeting with representatives of the Hospital Association was held in the headquarters of the Defense Council in the State Armory in Hartford on July 10. The meeting was presided over by Doctor George Smith and there were present Doctor Wilmar Allen, President of the Hospital Association, Albert W. Buck, Chairman of the Hospital Association's Committee on Medical Preparedness, Miss

Anna Griffin, Superintendent of the Danbury Hospital, Doctor Raymond Glazier, Superintendent of the Hartford Hospital, Mr. Andrews of the Defense Council, and Doctor Barker. Further study of existing hospital facilities and their emergency expansion and transportation and classification of sick and wounded were projected.

Waterbury Rehearses Disaster Emergency Plan

The Community disaster emergency plan that has been developed for the city of Waterbury by a subcommittee consisting of Doctor J. Harold Root, Doctor Andrew J. Jackson, Doctor Edward J. Godfrey under the direction of Doctor Ralph E. McDonnell, New Haven County Chairman on Medical Preparedness, had its first rehearsal on Sunday, June 15.

More than 500 persons participated in the demonstration involving doctors, nurses, hospitals, drivers of station wagons, state police, local police, boy scouts and others.

Scores of victims of a theoretical explosion which destroyed a factory and demolished a number of buildings were sent to the local hospitals and four emergency first aid stations that had been established for the Committee's medical defense organization. The Waterbury plan has been worked out in careful detail and the rehearsal under simulated disaster was held for the purpose of determining where the faults in the scheme were to be found.

Communications appeared to present the most difficult problem in carrying out a community disaster problem. Telephone lines, if they are intact and operable are congested with personal panic calls and that channel is hardly available for the emergency communications that go with the disaster relief. Short wave radio to police cars is workable but not adequate and the clearing of messages and directions to first aid and evacuation squads will require much further study and the devising of new methods to make it satisfactory.

Yale Announces Short Course for Nurses in the Preparedness Program

Yale University School of Nursing and the New Haven Hospital have announced a short refresher course in nursing for the many graduate nurses who are now professionally inactive and whose services may be required in the event of a national emer-

gency. The course will enable those interested to refresh their knowledge of nursing and to learn of the newer treatments and procedures. The purpose of such training is to provide a reserve group of nurses who could be called upon by the hospital should its staff be greatly depleted by the assignment of nurses to military duty. The course will cover a period of six weeks and will continue throughout the summer.

Changes in the Selective Service

Board 7B

John M. Monocella, Windsor, additional alternate examiner.

Board 11B

Samuel J. Goldberg, Sr., resigned.

Board 25B

Ralph H. Edson, Shelton, additional alternate examiner.

Board 31

Francis L. Herrick, Lakeville, alternate examiner in place of Howard Hansell who has entered military service.

Connecticut Physicians Ordered to Active Duty (As of July 12)

- *James R. Gudger, West Hartford
- Francis Y. Harrington, West Hartford
- *Alfred Kornblut, Bridgeport, United States Navy
- *Edward E. Williams, Naugatuck

Previous Orders Revoked

- *Justin L. Cashman, North Haven
- Stanley L. Garipay, Hartford
- Thomas L. Gingold, New Haven
- Thomas F. Hersey, Hamden
- *Louis Newton, Bridgeport
- *Francis B. Rafferty, Willimantic
- *Joseph S. Riccio, Hamden
- *William M. Rynard, Stamford
- Arthur S. Tucker, New Haven
- *Lloyd Wilcox, Terryville
- *Members Connecticut State Medical Society

The Alcohol Toll

The alcoholic death rates for Baltimore and Philadelphia were lower than those for New York for each of the years 1935-39, and the rates for Washington, D. C., were lower for each year except 1937, when it was the same; but arrests for drunkenness were from 27 to 47 times higher in Washington, from 14 to 31 times higher in Philadelphia and from 3 to 6 times higher in Baltimore than in New York. Boston has had the highest rates for both deaths and arrests. Its alcoholic death rates for the 6-year period were from 3 to 4 times higher than those for New York, but its arrest rates have been from 46 to 89 times higher.

Judge Joseph T. Zottoli, of the Municipal Court of Boston, using a less direct method than that followed by the Committee of Fifty, has made an exhaustive study of the relation between alcoholism and crime in Massachusetts. In a personal communication he states that more than 90 per cent of the adult population of prisons in Massachusetts, to which prisoners are sent for misdemeanors, are there because of offenses caused by drunkenness, and that about 50 per cent of persons receiving sentences to penal institutions have committed offenses related to alcoholism.

Public Health Report, March 14, 1941.

Epidemic Influenza

Thomas Francis, Jr., M.D., discusses the problem of epidemic influenza in *TRANSACTIONS & STUDIES* of the College of Physicians of Philadelphia, February 1941. In this discussion the author emphasizes the immunological differences in the two strains of influenza, A and B. At least two wide spread epidemics of influenza have been found to be caused by a virus which is sufficiently distinct serologically as to indicate that it is an entirely different virus. The author concludes, therefore, that it is obvious that there are fundamental differences in the causative agents of epidemic recurrences and that these differences are of primary significance for an understanding of immunity and the development of prophylactic measures.

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CREIGHTON BARKER, *Executive Secretary*

Amendments to the Medical Practice Acts Enacted by the 1941 Legislature

SUSPENSION, REVOCATION OR ANNULMENT OF LICENSE

Sec. 1. Suspension, Revocation or Annulment of License. The license or certificate of registration of any licensed or registered practitioner of the healing art in this state may be revoked, suspended or annulled, or such practitioner may be reprimanded or otherwise disciplined, after notice and hearing, on the recommendation of the examining board representing the branch of the healing art practiced by such practitioner for any cause named below. Proceedings relative to the revocation, suspension or annulment of a license or certificate of registration or toward disciplinary action may be begun by the filing of written charges, verified by affidavit, by the state department of health with the examining board representing the branch of the healing art practiced by the practitioner. The causes for which a license or certificate of registration may be revoked, suspended or annulled or for which a practitioner may be reprimanded or otherwise disciplined are as follows: Conviction in a court of competent jurisdiction, either within or without this state, of any crime involving moral turpitude, of any infamous crime or any crime in the practice of his profession; immoral, fraudulent, dishonorable or unprofessional conduct; illegal, incompetent or habitually negligent conduct in the practice of the healing arts; habitual intemperance in the use of spirituous stimulants or addiction to the use of morphine, cocaine or other habit-forming drugs; advertising in connection with the practice of the healing arts which is found by the board representing the branch of the healing arts practiced by the practitioner to be deceptive, misleading, extravagant, improbable or untrue; aiding or abetting the unlawful practice of any branch of the healing arts; failure to record a license or certificate of registration as required by law; insanity of the practitioner; fraud or deception in obtaining a license or certificate of registration.

The clerk of any court in this state in which a person practicing any branch of the healing arts shall have been convicted of any crime as described in this section shall, immediately after such conviction, transmit a written report thereof, in duplicate, to the state department of health, containing the name and address of the practitioner, the crime of which he was convicted, the date of conviction and the branch of the healing arts practiced by such practitioner, designating the examining board representing the branch of the healing arts practiced by such person, the written charge being accompanied by a copy of the report of the clerk of the court.

HEARING OF CHARGES; REVOCATION

Sec. 2. Hearing of Charges; Revocation. On receipt of a written charge, verified by affidavit, filed by the state department of health, the examining board shall transmit a copy thereof to the practitioner named therein and shall, at the same time, notify such practitioner of the place where a hearing will be held by the board on the charge and of the time of such hearing which shall be not less than ten days after the service of such notice. If a personal service on the practitioner or his counsel cannot be had, the secretary of the board shall cause to be published on three different days, at least thirty days prior to the hearing, a notice of the time and place of the hearing in a newspaper published in the county in this state in which such practitioner was last known to reside. A copy of the notice so published shall be sent by registered mail to the practitioner at his last-known address. The practitioner against whom a charge is filed shall have a right to a hearing before the board having jurisdiction, may appear in person or by counsel, or both, may produce witnesses and evidence in his behalf, and may question witnesses. The board may subpoena witnesses and papers in its own behalf and, if requested by the practitioner, may subpoena witnesses and papers in his behalf, may administer oaths, may compel the testimony of witnesses and may examine

witnesses. It may issue commissions to take testimony and the testimony so taken and sworn to shall be admissible in evidence for and against the practitioner. The attorney general shall, upon request, furnish legal assistance to the board. If the board, by a majority vote of its members, shall find the practitioner guilty of any of the charges preferred against him, it may, in its discretion, by written notice to the practitioner, reprimand or otherwise discipline him or it may recommend to the state department of health, in writing, that the certificate of registration of the practitioner be revoked or that it be suspended for a period of time to be set out in the recommendation. If the practitioner shall be found not guilty, the board shall order a dismissal of the charges. Upon receipt of a recommendation, as herein provided, that a certificate of registration be revoked or that it be suspended, the state department of health shall issue a revocation or suspending order, as the case may be, in compliance with such recommendation. One copy of such order shall be sent by registered mail to the practitioner at his last-known address and one copy shall be mailed to the town clerk of the town wherein the practitioner last resided. Such town clerk shall report such order in a book provided by the state department of health for the recording of certificates of registration and shall make a memorandum on the page where such practitioner's certificate of registration has been recorded, stating the book and page where such order of revocation or suspension has been recorded.

REQUIREMENTS FOR OBTAINING CERTIFICATES OF REGISTRATION

Sec. 3. Requirements for Obtaining Certificates of Registration. Except as hereinafter provided, no person shall receive a certificate of registration under the provisions of section 2746, as amended, until he shall have passed an examination before one of the examining boards appointed for such purpose by the governor, nor until he shall have filed with the state department of health a statement in duplicate, signed by a majority of the members of such board, certifying to the fact that the person named therein has been found qualified to practice medicine and surgery, and, in addition, a statement on a blank form furnished by said department, subscribed and sworn to by the applicant, embodying his name, age, place of birth, residence, the medical school from which he is a graduate, the date of his graduation and such other information as the blank form may call for. Each applicant for a certificate of registration shall, in addition to presenting a certificate as

required by section 2736 of the general statutes, as amended, submit proof satisfactory to the examining board having jurisdiction that he is not less than twenty-one years of age; is of good moral character; certified to by two reputable citizens of this state; is a citizen of the United States or has on file in the court having jurisdiction thereof a written declaration of his intention to become a citizen of the United States; is either a resident of this state, or intends in good faith permanently to reside in this state, or is a teacher in a medical school located in this state approved as provided in section four; has been a resident student through not less than four graded courses of not less than thirty-two weeks each in a medical school or schools approved as provided in section four and has received a diploma of graduation from such a school; if a graduate from such an approved medical school subsequent to January 1, 1919, has completed, before beginning the study of medicine, a course of study of an academic year consisting of not less than thirty-two weeks' duration in a college or scientific school approved by such board, which course included the study of chemistry, physics and general biology; and, if a graduate from an approved medical school subsequent to July 1, 1947, has completed, before beginning the study of medicine, a course of study of two academic years of not less than thirty-two weeks' duration each in a college or scientific school approved by such board, which course included the study of chemistry, physics and general biology. In lieu of the examination herein required, any of the examining boards, appointed under the provisions of section 2748 of the general statutes, as amended, may, under such regulations as the board may establish, accept a license from the board of medical examiners of any state in the United States or the District of Columbia or of any agency in such jurisdictions authorized to issue licenses to practice medicine, provided the applicant obtained such license after an examination of as high grade as that required for a certificate of registration in this state; has been a resident student through not less than four graded courses of not less than thirty-two weeks each in a medical school or schools approved as provided in section four and has received a diploma of graduation from such a school; is a citizen of the United States or has on file in the court having jurisdiction thereof a written declaration of his intention to become a citizen of the United States and a resident of this state or intends in good faith permanently to reside in this state, or

is a teacher in a medical school located in this state approved as provided in section four; has lawfully engaged in the practice of medicine in any state of the United States or the District of Columbia for a period of three years during the last five years immediately preceding the date of his application hereunder, any part of which period he may have served as an interne of any hospital approved by such board; and is of good moral character, and professional standing, as determined by such board. Upon the receipt of fifty dollars, the board may issue to such applicant a statement certifying to the fact that the person named therein has been found qualified to practice medicine and surgery. Furthermore, the board may, on the receipt of the sum of twenty-five dollars, likewise accept and approve, in lieu of the examination herein required, a diploma of the National Board of Medical Examiners, subject to the same conditions set forth in the preceding paragraph except that diplomates of the National Board of Medical Examiners shall not be required to have engaged in the practice of medicine for a period of three years, and may issue to such diplomate a statement certifying to the fact that the person named therein has been found qualified to practice medicine and surgery. A physician who shall have been graduated from a medical school, considered by the board as being acceptable, who began the practice of medicine outside of this state prior to May 23, 1893, and who shall appear before any of the examining boards appointed under section 2748, as amended, may on the payment of the sum of fifty dollars to such board, receive without examination a statement that the person named therein has been found qualified to practice medicine, if the board shall find that the applicant is a citizen of the United States or has on file in the court having jurisdiction thereof a written declaration of his intention to become a citizen of the United States; is a resident of this state, or intends in good faith permanently to reside in this state, or is a teacher in a medical school located in this state approved as provided in section four; has engaged in the practice of medicine for a period of six months during the year immediately preceding the date of his application; is of good moral character and professional standing, as determined by the board; and has a license authorizing him to practice medicine in the state in which he shall have resided immediately preceding his application. Any person who shall have complied with the requirements of this section and who shall file the proof thereof with the

state department of health, shall receive from the department, upon payment of two dollars, a certificate of registration which shall include a statement that the person named therein is qualified to practice medicine and surgery. Each of the examining boards provided for in section 2748, as amended, shall file with the state department of health, within thirty days after each examination, a list of all applicants who have appeared before the board and the results of their examination.

EXAMINATION

Sec. 4. Examination. The examining boards provided for by section 2748, as amended, shall hold examinations on the second Tuesdays of March, July and November of each year, at such places as they may designate and at such other times and places as they shall determine. Applicants for certificates to practice medicine or surgery shall be examined in anatomy, physiology, medical chemistry, obstetrics, hygiene, surgery, pathology, diagnosis, therapeutics, practice and materia medica, and in such other subjects as the examining board may deem necessary, provided each applicant for examination shall be notified concerning the subjects in which he is to be examined. Each of said boards shall prepare its own questions and shall make rules and regulations for conducting its examinations and for the operation of the board as, from time to time, it shall deem necessary and both questions and answers shall be filed with and preserved for at least six years by the state department of health. Each applicant for examination shall be examined by the board representing the same school of practice in which the applicant was graduated. Before being admitted to the examination, an applicant shall pay to such board the sum of twenty-five dollars and an applicant rejected by an examining board may be re-examined at any subsequent meeting of such board, upon payment of the sum of twenty-five dollars for each appearance. Upon receipt of the duplicate statements as provided in section three, the state department of health shall forward one of such duplicate statements, together with the statement that a certificate of registration has been issued, to the town clerk of the town wherein the person filing such statements resides, and, in case such person shall not reside in this state, the state department of health shall hold such statements until notified by such person of the name of the town in this state in which he intends to reside, when said department shall transmit such statements to the town clerk of such town, and such town clerk shall record the

same in a book to be provided for that purpose by the state department of health, and shall then return the same to the person who filed such statements with said department; and such town clerk shall receive for such recording a fee of twenty-five cents, to be paid by the state department of health from the amount paid to it as aforesaid. Annually during the month of January the secretary of each of the said examining boards shall file with the state department of health a list of approved medical schools or institutions, graduates from which may be admitted to examination before said boards. Such list of approved schools may be revised from time to time at the discretion of the board.

Sec. 5. Sections 2741, 2742, 2747 and 2749 of the general statutes, as amended, are repealed.

THE FORUM

In 1885 Randolph introduced mineral oil as a therapeutic agent for the relief of intestinal stasis. Since then and with many variations it has become a professional and household byword for constipation. While such popularity may be deserved, it is well to remember that there are definite physiologic and pathologic objections to its use; objections that are serious enough to warrant careful consideration. Normally, the defecation reflex is set up when the fecal column passes the recto-sigmoid junction and creates pressure in the rectum. This mechanism is disrupted when oil is administered. The abnormally fluid stool seeps past this junction into the rectum and makes it a reservoir of fecal matter, a job normally assigned to the transverse, descending and sigmoid colons. This seepage is usually insufficient to start the defecation reflex and, as a result, the rectum is kept partially full, subject to constant local irritation.

Another physiologic objection is that the ingestion of mineral oil disturbs normal metabolism. Fat soluble vitamins are carried away, thereby setting up a deficiency. Food is hurried through the intestines and much of its value made unavailable. The oil does not allow sufficient time for proper digestion and assimilation; and by coating the intestinal villi, creates a mechanical obstruction to absorption. The resultant weight loss can reach serious proportions in children and elderly invalids, the most frequent victims of an oil regime.

From a pathological standpoint there are some major objections. When given post-operatively in hemorrhoidectomies it may delay healing and indirectly cause late hemorrhage. This fact is equally important in fissures and bleeding hemorrhoids. It is also involved as a cause and aggravator of pruritus ani, cryptitis, proctitis and intertrigo. Fecal stained oil leaking through the external opening makes it impossible to maintain local cleanliness. Finally, careful experimental and post-mortem work has demonstrated that degenerative changes occur in the liver, spleen and other organs due to absorption of the oil into the bloodstream. In the light of these facts, it is necessary to revise our previous concepts of the harmlessness of this medication and to limit its use to temporary applications. In the meantime more suitable measures should be instituted.

Valuable as they have proved to be, the sulfonamide drugs have not yet reached a static stage. New compounds and new uses for the older ones are constantly appearing in the literature. During the past few months, three interesting variations of their local application were reported. In London, several groups of investigators, egged on by the overcrowded conditions of the air-raid shelters, experimented with antiseptic snuffs made up with sulfanilamide or sulfathiazole. These were dispersed throughout the nasal passages. No great claims were made for this procedure, but it was felt that results were good enough to demand further work. No toxicity from such use was reported. In this country solutions of 5% and 10% soluble sulfathiazole are being used in the treatment of nasal infections, as irrigations for infected deep wounds, and as compresses on infected burns. Also being tried for the same indications are suspensions of sulfadiazine. Early reports are quite favorable.

This is the open season for athlete's foot—trichophytosis—of the toes. The most common source of reinfection is the shoe, and the problem of how to effectively sterilize that shoe is a recurrent one. Most effective, harmless and practical way is to rinse out the shoe every night with a 5 or 10% solution of formaldehyde. Turn them over, soles up and allow to dry overnight. They can then be worn the next day without harm.

T. P. R., M.D.

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

CLIFFORD KUH, M.D., Chairman, New Haven

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ALBERT S. GRAY, M.D. Hartford	ARTHUR B. LANDRY, M.D. Hartford	RICHARD O'B. SHEA, M.D. Bridgeport	

Resume of State Activities

Connecticut makes an unusually good showing in a report of "Industrial Hygiene Activities in State and Local Health Departments," recently issued by the Division of Industrial Hygiene of the National Institute of Health, Bethesda, Maryland. Activities for the year ending June 30, 1940, are analyzed for 19 states and 2 cities out of 32 states and 4 cities having industrial hygiene units.

For all states there were 1,504 field studies involving 98,488 workers. Connecticut takes second place with 251 studies (exceeded only by Baltimore with 628) and fourth place with 10,335 workers involved (California, 18,147; North Carolina, 13,306, and Utah, 10,478).

These field studies were the result either of planned investigative programs or the requests of industry, labor or other interested groups. In respect to studies made by request Connecticut leads all other states with 103 out of a total of 327, which is over double the number of the second state, California, which reports 44.

It is interesting to note that 36 per cent of the requests for investigations came from labor or those administrative agencies whose chief function deals with the welfare of workers. In fact, 78 per cent of all the requests made came from labor and industry, with only 22 per cent coming from local health agencies and other organizations. This finding clearly indicates the recognition on the part of industry and labor of the existence of potential hazards and a desire to do something about them.

Only 3 per cent of the investigations analyzed in this study resulted from reports of occupational disease. These follow-up studies of occupational diseases involved only 5 per cent of all the workers included in the present analysis. It is evident that

much still needs to be done to stimulate the reporting of absenteeism due to disability and still more needs to be done with reference to the follow-up work so vital if a recurrence of such diseases is to be obviated.

Outstanding Achievement

Mercurial poisoning in the felt hat industry will soon be no more. The finding of a satisfactory substitute for mercury after years of research and the obtaining of unanimous consent upon the part of manufacturers to use the substitute, is an epochal achievement by the Bureau of Occupational Diseases of the Connecticut State Department of Health, which "will take its place, along with the measures used in eliminating phosphorus in the manufacture of matches, as one of the historical mileposts in the progress of preventive medicine." Doctor Albert S. Gray, Director of the Bureau has through his contribution to this achievement alone earned his place in the sun.

At a conference of fur cutters, hat manufacturers, labor and health officials, called in Washington on May 14, 1941, by the Surgeon General, it was agreed: "Effective December 1, 1941, the use of mercurial carrot in the preparation of hatters' fur, or the use of mercurial carroted hatters' fur in the manufacture of hats, is prohibited."

The chief ingredient of non-mercurial carroting substitutes is Glauber's salts.

Status of Certification

The certification of industrial physicians and surgeons appears to be a step nearer. At the meeting of the Section on Preventive and Industrial Medicine and Public Health of the American Medical Association on June 4, 1941, Doctor Robert T. Legge, Berkeley, California, read a resolution adopted by

the American Industrial Physicians and Surgeons in May, 1941, to the effect that a committee representing the physicians and surgeons "coöperate with a similar committee from the related section of the American Medical Association to further the establishment of an American Board of Industrial Medicine and Surgery and to seek the approval for this American Board of Industrial Medicine and Surgery by the Advisory Board for Medical Specialties."

The purport of the resolution was favorably acted upon. A coöperating committee, consisting of Doctors Leverett D. Bristol, New York, Robert T. Legge, Berkeley, California, and W. A. Sawyer, Rochester, New York, was appointed to represent the section on Preventive and Industrial Medicine and Public Health of the American Medical Association and to work with the Association of Industrial Physicians and Surgeons toward the organization of a certifying board.

Publishes Composite Guide

The Division of Industrial Hygiene of the Department of Public Health of Illinois has recently published a manual, entitled, "Health Hazards of Occupational Environments," which is intended to serve as "a guide for industry, labor, the medical profession and public health personnel." It discusses sanitation facilities, ventilation, illumination, fatigue, industrial dusts, solvents, gases, dermatitis, poisoning due to heavy metals and the effects of atmospheric variations. The department offers all interested groups a comprehensive medical, chemical, engineering and educational service, as well as the undertaking of any special studies requested. The publication is a useful reference booklet for physicians.

The Industrial Nurse

In an excellent article on the subject of the "Relationship of the Nurse in Industry to the Physician," in the March, 1941, issue of the *Wisconsin Medical Journal*, Doctor Stanley J. Seeger, Chairman of the Council on Industrial Health, American Medical Association, discusses the newer concepts concerning the usefulness of the nurse in industry. He says, "In the small plant the nurse will find that a restriction of her duties to the clinical type of service will not justify her employment, and the necessity of well understood and well defined medical contacts and supervision are most needed in this particular field. If the physician's concept of industrial nursing is based purely on ideas of clinical nursing obtained in hospital practice, the nurse will find it difficult to fulfill all of the possibilities in the industrial field. In order properly to develop the possibilities of nursing services in industry, the nurse should be trained in sanitary inspection and supervision and employment activities, in the maintenance of legal requirements of health control, in safety supervision, in recreational programs and in the safeguarding of conditions connected with eating facilities. Her value in the small plant is proportional to her ability to take responsibility for other than usual clinical activities.

"This definition of the place of the nurse in industry is somewhat extended because it serves as a basis for discussing her relationships with the physician. Because of the fact that nurses are often employed through non-medical personnel management in plants, the medical contacts are, in many instances, of a casual nature. The necessity of establishing the proper liaison between the medical profession and the large body of nurses now practicing in small industry with relatively little medical supervision is obvious. As this field of nursing endeavor develops, the need for medical supervision will become more and more apparent."

Comment on "Conservation"

The brochure, entitled "Conservation of Man Power," which was prepared by the Joint Committee on Industrial Health of the Manufacturers Association of Connecticut and the Connecticut State Medical Society for distribution to Connecticut industrialists, has evoked favorable response from numerous sources, some of which are, as follows:

Journal of the American Medical Association, editorial in issue of June 21, 1941: "This example of civic and professional leadership is a proper function of the organized medical profession and a far reaching experiment in public relations. It deserves emulation by medical societies everywhere."

Lewis E. MacBrayne, Regional Representative, National Committee for the Conservation of Manpower in Defense Industries: "An admirable plan" and "a definite contribution to the problem. It might well be followed by our other excellent New England manufacturers' associations." Special mention was made of the brochure in a bulletin from Mr. MacBrayne to all New England defense industries, with the suggestion that the industrialist endeavor to obtain a copy for his own use.

Thomas A. Hendricks, Executive Secretary, Indiana State Medical Association: "The Executive Committee of the Indiana State Medical Association is much impressed with the report entitled 'Conservation of Man Power,' prepared by the Connecticut State Medical Society and the Manufacturers Association of Connecticut. You certainly have done a beautiful job."

Professor C.-E. A. Winslow, Department of Public Health, Yale University, School of Medicine: "I have been very greatly pleased to see the excellent and well deserved publicity obtained for your State Manufacturers Association report."

Doctor Clarence D. Selby, Medical Director, General Motors Corporation, Detroit: "My sincere congratulations to the Committee. This is by all odds the best effort in this direction that I have yet seen."

B. E. Kuechle, Vice-President, Employers Mutual Liability Insurance Company, Wausau, Wisconsin: "Would it be possible to secure about a dozen additional copies? You certainly did a grand job here."

Numerous other requests for copies of the brochure have been received, according to A. E. Whitehill, Executive Assistant of the Manufacturers Association of Connecticut, who writes: "Hardly a day goes by but what we are receiving requests for copies of 'Conservation of Man Power.'"

OUR NEIGHBORS

Massachusetts

According to a report made to the Council of the Massachusetts Medical Society at its annual meeting in May by the chairman of the Physical Therapy Committee, a clinic of physical therapy has been established at the Massachusetts General Hospital. The director of the clinic, Doctor Watkins, has been appointed assistant professor of medicine at Harvard Medical School.

Vermont

Each year since the enactment of social security legislation, Vermont has made a considerable increase in its expenditures for maternal and child-health work. Also the percentage of total expenditures drawn from State and local funds has increased each year, from 32 per cent in 1937 to 44 per cent in 1940.

Under Vermont's first maternal and child-health plan submitted under the Social Security Act in 1936, the staff consisted of the director, 8 public-health nurses, and 3 dental hygienists. The plan for 1941 includes the director, a dental adviser, 2 full-time local dentists, a nutritionist, and 27 public-health nurses. It also provides for obstetric consultation in certain areas. The amount budgeted for payment to local practicing physicians and dentists for services to mothers and children at clinics and conferences has been increased 40 per cent and consultation service by practicing obstetricians and hospitalization and medical treatment for children have been added.

Some results of the efforts on behalf of mothers and children can now be pointed out. In the period 1934-39 there occurred a decline of 32 per cent in the maternal mortality rate in the United States, the greatest decrease ever recorded for a similar period in this country. With this decrease in mortality it is reasonable to believe that there has been a considerable decrease in illness and disability associated with maternity, but unfortunately we have no means of measuring this. The decrease in maternal mortality was accompanied by a decline of 20 per cent in the infant death rate and 11 per cent in the stillbirth rate.

In the State of Vermont during this period there was a decline of 8 per cent in the maternal death

rate, 13 per cent in the infant death rate, and 18 per cent in the stillbirth rate. The maternal and infant mortality and stillbirth rates are somewhat lower in Vermont than in the United States as a whole.

From paper given at Conference on Health for Children in Vermont, Montpelier, February 11, 1941, by Clara E. Hayes, M.D., Maternal and Child Health Division, U. S. Children's Bureau.

NEWS

from County Associations

Fairfield

The Bridgeport Medical Association held its annual outing at the Shoreham Country Club, East Norwalk, on Wednesday, July 16. Following an early lunch the golfers teed off at one o'clock. Tennis, soft ball, quoits, horseshoes and swimming were on the program. Dinner at seven and the awarding of prizes for athletic prowess brought to a close a delightful day.

On June 3 Doctor Ralph Bowers addressed the Bridgeport Medical Association on the subject, "Treatment of Carcinoma of the Stomach in The Aged Individual."

Doctor Clifford F. Ryder has opened an office for the practice of obstetrics and gynecology at 77 Bedford Street, Stamford.

Frank L. Fisher, M.D., left Stamford in June to do volunteer medical service in Great Britain.

Lieut. James E. Crane of the 45th Medical Battalion, Third Armoured Division, has been ordered to the school of aviation medicine at Randolph Field, Texas.

Doctor Jay E. Starrett was installed recently as president of the Stamford Lions Club and Doctor Ralph W. Crane is the new president of the Stamford Rotary Club.

Doctor Charles E. Murphy was appointed Assistant Pediatrician on the staff of the Stamford Hospital.

E. Tremain Bradley, M.D., has opened an office at 28 Elm Street, New Canaan. Doctor Bradley is limiting his practice to surgery, gynecology, and obstetrics.

Hartford

Changes in decoration and in study quarters at the Hartford Medical Library building are progress-

ing rapidly. New book-stacks are being installed in the basement and the front of the first floor is being refurnished. These alterations will be a welcome surprise when meetings resume in September and will add to the facility and comfort of those using the library.

In trying to be as alert as other organizations, the hospitals of Hartford have been considering means of taking care of injuries in case of local catastrophe. While such preparations would seem fantastic "only yesterday," they are not at the present time for we have all around us factories, extensively and intensively engaged in National Defense production. While the possibilities of bombing are quite remote, sabotage is a thing that can be readily feared. One definite need so far as concerns East Hartford is the necessity of having ferries available for wounded in case of congestion on the Boulevard bridge or damage to it. The plans so far outlined represent a thoughtful step in a direction which will, we may be sure, lead to more efficient ones.

Doctor A. M. Rowley, now retired from practice in Hartford and living in Florida, has given evidence by way of photographs sent to several of his friends of his prowess and good fortune as a deep sea fisherman. Recently he caught a tuna weighing 126 pounds.

Middlesex

Doctor Clair B. Crampton has announced the opening of an office in the Central National Bank Building, Middletown, for the practice of obstetrics and gynecology.

Members of the Central Medical Society enjoyed an outing at Clarkhurst the latter part of June, ending the activities of the society until fall. The event which was in charge of Doctor Philip Schwartz of Portland, president of the medical group, was highly successful. The extreme heat of the day kept attendance somewhat lower than in past years.

A field day consisting of field events and a baseball game was held at the Connecticut State Hospital on July 30. This is an annual event sponsored by the staff for the benefit of the patients.

Doctor Roy H. Leak, Superintendent of the Connecticut State Hospital in Middletown, has announced that Doctor J. Claude Statham has joined the staff as a Senior Physician. Doctor Statham is a transfer from the Norwich State Hospital and served in a similar capacity at Florida State Hospital,

Chattahoochee, Florida, and U. S. Veteran Administration Facilities.

Three undergraduate medical students are serving as interns at the Connecticut State Hospital, Middletown, during the summer. They are Mr. Frank Marino of University of Maryland Medical School, Mr. Paul Sherwood of Boston University Medical School, and Mr. Samuel Susselman of Albany Medical School.

Doctor Leak also announced that at the end of the fiscal year there were 2971 patients in the Hospital, the normal capacity being 2628. Since the districting of the State in regard to State hospital admissions, the number of patients admitted to the hospital in Middletown has decreased. There is still a large number of senile patients being admitted.

New London

Doctor Eric Goldmeir, ex-interne at the Lawrence and Memorial Associated Hospitals, New London, has opened an office in Groton for the general practice of medicine.

Doctor Shirley Baron, New London, attending otolaryngologist and bronchoscopist at the Lawrence and Memorial Associated Hospitals, New London, was elected to membership June 3, 1941 in the American Broncho-Esophagological Association. Doctor Baron was elected to this scientific body in recognition of a thesis submitted November, 1940.

News from Yale University School of Medicine

The annual meeting of Yale Alumni in Medicine took place on the afternoon of June 16 in Brady Auditorium. Among the features of the business meeting were the announcement of prize awards to members of the graduating class, a gift from the Association in memory of Doctor Harry Burr Ferris, to start a fund for purchase of books on anatomy, the presentation of a medical book-purchasing fund by the Class of 1931 in memory of Jean Jacques DuMortier of that class, and the presentation of two portraits to the Medical School; one was of Doctor Henry Lawrence Swain and was a gift from associates and friends, and the other was of Doctor Ralph A. McDonnell and was given by

his classmates of Yale College, 1890. The principal address was given by Doctor George Cahill, professor of urology at the College of Physicians and Surgeons of Columbia University, who spoke on medical preparedness. Dean Blake outlined the year's progress in the medical school, described proposed changes in the medical school curriculum, and announced that the schedule of the clinical years would run continuously beginning in July. A social gathering took place immediately afterward in the clubroom of the Sterling Hall of Medicine.

The Thirty-ninth General Hospital, affiliated unit of the Army Medical Corps sponsored by the Yale School of Medicine, assembled at Wilcox's Pier Restaurant, Savin Rock, on Friday, June 27. Following a dinner, which was attended by 40 members of the unit, Doctor George M. Smith related experiences of the Yale Mobile Hospital Unit, of which he was a member in the first world war. Doctor Joseph Sadusk and Doctor Max Taffel spoke briefly about the application of sulfonamide drugs in medical and surgical conditions in war time. Doctor James C. Fox, Jr., who is unit director, discussed various matters of peacetime organization.

Containers holding specific products such as aspirin, or vitamin B tablets are crated for shipment abroad so that each case holds only one specific kind of supply and is ready for immediate use by medical men overseas. Every step of this procedure—opening the sample boxes, sorting them, putting them in labeled containers, and consigning them to the proper crate—is done directly under the supervision of trained nurses who volunteer their services to us.

Point number two—we work directly from lists of needed materials which are supplied to us by the British Ministry of Health and overseas relief agencies. No item ever leaves this office unless we have a specific request for it.

Thirdly—ever since this organization started, we have had very generous and wholehearted coöperation from the American Pharmaceutical Association. Their members have supplied us with valuable materials on many occasions when we have been asked for supplies for which donations have not been received.

Thanking you for your courtesy and with best wishes for the continued success of the Journal, I am,

Sincerely yours,

EUGENE M. BLAKE, M.D.

*Journal V. 6, 433 (June 1941).

LETTERS TO THE EDITOR

EUGENE M. BLAKE, M.D.
303 Whitney Avenue
New Haven, Conn.

July 7, 1941

Editor,
The Connecticut State Medical Journal
Hartford, Connecticut.

Dear Doctor:

As a National member of the Medical and Surgical Relief Committee, I felt that I should take up with that organization the note which appeared in the May issue of the Journal,* and which seemed rather prejudicial to the work which we have attempted to do, so may I ask you to present to the readers of the Journal the following facts, in order that both sides of the question may be made clear.

It is not true that we send "heterogeneous" material in an "expensive and uncontrolled" manner. When sample supplies come to this office, they are unwrapped and placed with other identical products in large glass containers which are carefully labeled.

OBITUARIES

Bernard Patrick Murphy, M.D.

1871 - 1940

Bernard Patrick Murphy, a practicing physician in Putnam for nearly forty five years and one of the oldest members of the medical profession in Putnam, died December 14, 1940 at the Day Kimball Hospital after a long illness. He was sixty nine years old. He sustained a fracture of the hip in a fall about two years prior to his death and had been in failing health since that time.

Doctor Murphy was born in Putnam on September 8, 1871, a son of Anthony and Mae Fallon Murphy. After attending St. Mary's Parochial School in Putnam he was a student at the high school of St. Charles College in Baltimore, Maryland. He graduated from the University of Ottawa after the completion of a premedical course in 1890,

and five years later received his degree of Doctor of Medicine from Jefferson Medical College in Philadelphia. After completing his medical education Doctor Murphy practiced medicine for a time in Naugatuck, Connecticut, and then returned to Putnam where he was a practicing physician until two years ago when ill health made it necessary for him to retire.

During the Spanish American War Doctor Murphy served his country as a member of the Putnam National Guard unit and up to the time of his death had been an active member of the A. Wilder Merriam Post, United Spanish War Veterans of this city. He was a member of the Cargill Council, Knights of Columbus, and the Irish American Club of Putnam.

Doctor Murphy married Miss Catherine Shelley forty years ago. Surviving Doctor Murphy are his wife, a daughter Miss Eleanor Murphy, principal of the Israel Putnam School, Putnam, two sons, Francis H. Murphy, former Mayor of Putnam, and now superintendent of the Belding Heminway Corticelli Co., and Charles Murphy, principal of the Junior High School at Amherst, Mass., a sister Mrs. M. E. Smith of Hartford, and a brother Michael Murphy of Utica, N. Y.

With the passing of Doctor Murphy his medical brethren lose a companionable colleague and his patients lose a sincere and comforting physician.

Joseph A. LaPalme, M.D.

William H. Slaughter, M.D.

1878 - 1941

On the afternoon of June 4, 1941, William H. Slaughter, M.D., Health Officer and Medical Examiner for many years in Darien, died without warning at the Noroton Presbyterian Church while addressing the Connecticut Public Health Nursing Association. He was born in the year 1878 and received his medical degree at Columbia University in 1907 and came to Darien in 1920.

He was a man endowed with the essentials of life who applied his principles of medicine to his patients in an understanding way. Doctor Slaughter endeared himself to the community by his honor and sincerity with a full knowledge of affairs in medicine, ending his days in this world, as any physician would wish, while so actively engaged.

Ralph W. Crane, M.D.

QUARTO NOTES

MEDICAL DIAGNOSIS AND SYMPTOMATOLOGY.

(5th edition.) Samuel A. Loewenberg, M.D., F.A.C.P. Philadelphia: F. A. Davis Company. 1941. 1139 double-column pages. 517 illustrations. 27 color plates. \$12.00.

Reviewed by WILSON FITCH SMITH

This is the fifth edition since 1929 of a subject that requires constant revision because of newer techniques and discoveries. The previous editions were entitled "Diagnostic Methods and Their Interpretations in Internal Medicine". In this fifth edition, Doctor Loewenberg has rewritten the greater part of the volume, adding much new material and deleting some of the less important text that has become obsolete.

In writing this book the author has chosen a herculean task, that of covering the whole field of diagnostics in internal medicine. This includes symptomatology, physical diagnosis—a textbook subject in itself—as well as the many laboratory analyses now available. Doctor Loewenberg solves this problem with skill by discussing fully and at length the respiratory and cardiac symptoms; devoting adequate space to the digestive system, the nervous system and urology; whereas to the skin, eye, ear, nose and throat, bones and joints, radiology, blood, etc., he allots space enough only for the purpose of a general examination. Little attempt is made to give more than the simplest details of laboratory procedures, emphasis being put on the interpretation of the results submitted to the practitioner by the various laboratory specialists.

Mechanically much has been done to present the subject in a clear and readily grasped form. Good sized print on double column pages with excellent paragraph headings makes it easy to study the large amount of material presented, although the glossy surface of the pages tends to reflect light. A number of splendid tables on differential diagnosis, etc., save time and add clarity to the discussion. The illustrations are particularly good, only a few of the darker ones suffering by reproduction. The color plates of the exanthemata, blood smears, gastroscopic views, etc., are very true to life.

Because of the huge scope of this text, it is possible to find a few small omissions, such as omitting acute rheumatic fever as one of the causes of abdominal pain, and omitting "Stokers' Cramps" from NaCl depletion as one of the causes of muscular cramps, but by and large the catalogue of symptoms and differential diagnoses is complete. Particular attention has been given to the investigation of the human being who is the sum of all his component parts and systems, and yet in outlining the form for history taking it seems that not enough is made of the emotional background—home, employment, avocations, sex life, etc.—which so often is important in the production of functional disorders in our modern life of tension and high speed.

This edition of MEDICAL DIAGNOSIS AND SYMPTOMATOLOGY should continue to prove useful to the internist, general practitioner and medical student, but par-

(Continued on page 628)

ROSTER OF MEMBERS, 1941

CONNECTICUT STATE MEDICAL SOCIETY

OFFICERS

President: JAMES D. GOLD, Bridgeport
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 Annual Meeting, Second Tuesday in April, at Bridgeport
 Semi-Annual Meeting, First Wednesday in October

BETHEL

1940 Grigas, John E., 218 Greenwood Ave.
 1925 Moore, Homer Franklin, 4 Grand Ave.
 1938 Trimper, Albert J., 155 Greenwood Ave.
 1939 Wolfson, Dexter, 58 Greenwood Ave.

BRIDGEPORT

1933 Adzima, Joseph Matthew, 409 Noble Ave.
 1941 Akerson, Irving B., Bridgeport Hosp.
 1932 Alpert, Max, 881 Lafayette
 1935 Antell, Maxwell Joseph, 1690 Barnum Ave.
 1920 Apsel, Abraham, 1620 Fairfield Ave.
 1928 Backer, Marcus, 881 Lafayette
 1938 Bakunin, Maurice Irving, 654 Clinton Ave.
 1916 Banks, Daniel Tony, 385 Barnum Ave.
 1913 Beudry, Joseph Horace, 109 Rowsley
 1913 Bernstein, Abraham, 472 State
 1900 Blank, Elmer Francis, 387 Noble Ave.
 1935 Bogin, Maxwell, 144 Golden Hill
 1921 Booe, John Grady, 144 Golden Hill
 1941 Brier, Hyman D., 2583 Main
 1927 Brodsky, Michael Emanuel, 881 Lafayette
 1940 Brooks, Paul Lester, 1260 East Main
 1939 Buckhout, George Atherton, 2911 Fairfield Ave.
 1938 Buckley, John William, 2080 North Ave.
 1923 Buckmiller, Frank Charles, 1119 Stratford Ave.
 1940 Burns, Bernard J., 1101 East Main
 1919 Calvin, Claudius Virgil, 144 Golden Hill
 1920 Carroll, Francis Patrick, 919 Fairfield Ave.
 1932 Carroll, Philip Roger, Jr., 1131 Noble Ave.
 1940 Castaldo, Louis F., 47 Goodsell
 1920 Cheney, Maurice Lionel, 144 Golden Hill
 1941 Clark, William Thompson, 881 Lafayette
 1924 Conklin, Cornelius Stephen, 468 Clinton Ave.

1936 Connors, Edwin Robert, 416 Boston Ave.
 1940 Coon, William Hall, R. F. D. No. 1
 1935 Creaturo, Nicholas Edward, 1286 East Main
 1913 Curley, William Henry, 881 Lafayette
 1908 Curran, Philip John, 144 Golden Hill
 1894 Day, Fessenden Lorenzo, 819 Myrtle Ave.
 1920 DeLuca, Horatio Roger, 881 Lafayette
 1935 Del Vecchio, Leonard Frederick, 763 Noble Ave.
 1921 DeWitt, Edward Nicholas, 881 Lafayette
 1941 Duzmati, Paul Peter, 258 Kent Ave.
 1941 Eddy, Maxon Hunter, 881 Lafayette
 1939 Edgar, Katherine Jean, 105 Beacon
 1937 Eimas, Aaron, 881 Lafayette
 1939 Esposito, Joseph John, 2212 Main
 1913 Finkelstone, Benjamin Brooks, 144 Golden Hill
 1897 Fleck, Harry Willard, 897 Lafayette
 1938 Foley, Francis Xavier, 2992 Main
 1908 Formichella, John B., 797 Washington Ave.
 1916 Gade, Carl Johannes, 144 Golden Hill
 1939 Gaffney, Charles Bernard, 850 Howard Ave.
 1929 Garbelnick, David Abraham, 1102 E. Main
 1907 Gardner, Charles Wesley, 144 Golden Hill
 1916 Garlick, George Burroughs, 144 Golden Hill
 1940 Geer, William Allyn, 881 Lafayette
 1916 Gilday, James Lowry, 819 State
 1927 Gildea, Mark Andrew, 881 Lafayette
 1895 Gold, James Douglas, 839 Myrtle Ave.
 1927 Greenspun, David Stoven, 144 Golden Hill
 1916 Griffin, Daniel Patrick, 1278 E. Main
 1923 Griswold, Arthur Sheldon, 144 Golden Hill
 1928 Griswold, Crawford, 144 Golden Hill
 1920 Groark, Owen James, 881 Lafayette
 1913 Hale, Frary, 144 Golden Hill
 1941 Hall, Rufus Warren, 66 Park
 1939 Hardenburg, Daniel Bailey, 881 Lafayette
 1937 Harper, Paul, 144 Golden Hill
 1928 Harshbarger, Isaac Long, 144 Golden Hill
 1920 Havey, Leroy Austin, 144 Golden Hill
 1938 Hennessey, Joseph Gerard, 108 Rowsley
 1915 Hippolitus, Paul DiFrancesca, 255 Barnum Ave.
 1930 Hooper, G. Herbert, 1643 E. Main
 1933 Horn, Benjamin, 620 Clinton Ave.
 1916 Horn, Martin Irving, 915 North Ave.
 1920 Howard, Joseph Henry, 144 Golden Hill
 1938 Hurlburt, Edward Glens, 3366 Main
 1912 Hyde, Charles Elias, 881 Lafayette
 1932 James, Arthur Gregory Boswell, 1424 Stratford Ave.
 1932 Kalman, Eugene, 1389 Fairfield Ave.
 1927 Keegan, Daniel Francis, 144 Golden Hill
 1938 Keys, Robert C., 881 Lafayette
 1924 Kneale, Halford Benson, 144 Golden Hill
 1941 Knepp, James Warren, 144 Golden Hill
 1924 Kornblut, Alfred, 1539 Fairfield Ave.
 1913 Lambert, Henry Bertram, 144 Golden Hill
 1926 Laszlo, Andras E., 881 Lafayette

- 1940 Lengyel, Paul, 500 Clinton Ave.
 1925 Levenson, Albert, 881 Lafayette
 1904 Leverty, Charles Joseph, 528 Park Pl.
 1933 Levinsky, Maurice, 480 Noble Ave.
 1927 Levy, Maurice Noel, 480 Clinton Ave.
 1940 Little, Olga A. G., 1278 East Main
 1931 Lockhart, Reuben Harold, 144 Golden Hill
 1937 Lynch, Hubbard, 881 Lafayette
 1887 Lynch, John Charles, 826 Myrtle Ave.
 1904 Lynch, Robert Joseph, 144 Golden Hill
 1941 Martin, Raymond Alfred, 654 Clinton Ave.
 1932 Marglis, Ben, 171 Harrison
 1922 Maxwell, John Alphonsus, 919 Stratford Ave.
 1938 McLean, Thomas Smith, Jr., 1403 Boston Ave.
 1923 McManus, James Patrick, 1390 E. Main
 1913 McQueeney, Andrew Michael, 1315 Noble Ave.
 1931 Meyer, Fritz Martin, 144 Golden Hill
 1892 Miles, Henry Shillingford, 144 Golden Hill
 1940 Monahan, David Tuite, 144 Golden Hill
 1932 Mooney, Sydney, 1116 Stratford Ave.
 1936 Murray, William J. C., 784 Noble Ave.
 1938 Nespeco, James V., 2546 Main
 1901 Nettleton, Irving La Field, 775 Washington Ave.
 1919 Neumann, Harry Aaron, 588 State
 1937 Newton, Louis, 881 Lafayette
 1925 Nichols, Charles William, 1221 Stratford Ave.
 1920 Nickum, John Stanley, 144 Golden Hill
 1936 Nolan, John Francis, 1260 E. Main
 1925 O'Brien, Francis James, 74 Circular Ave.
 1941 O'Connell, John Gabriel, 144 Golden Hill
 1940 Panettieri, Andrew Joseph, 3084 Main
 1921 Parmelee, Berkley Melvin, 144 Golden Hill
 1937 Pascal, Thomas J., 385 Noble Ave.
 1909 Patterson, Daniel Cleveland, 881 Lafayette
 1930 Pileggi, Peter, 743 Washington Ave.
 1935 Plukas, Joseph Martin, 339 South Ave.
 1933 Quatrano, Joseph Charles, 835 Fairfield Ave.
 1916 Quinn, John Francis, 144 Golden Hill
 1941 Quinn, Katherine Sarah, 127 Ann
 1916 Reich, Upton Sharetts, 2095 Main
 1940 Reiter, Benjamin Reynolds, 144 Golden Hill
 1938 Ribner, Harold, 881 Lafayette
 1918 Roberts, Edward Russell, 144 Golden Hill
 1913 Roche, Thomas Joseph, 1815 Noble Ave.
 1936 Rockwell, Alice Elizabeth, 1775 Noble Ave.
 1928 Sekerak, Arthur Joseph, 938 E. Main
 1938 Sekerak, Raymond Andrew, 1458 E. Main
 1938 Sekerak, Richard John, 938 E. Main
 1938 Shea, Cornelius Joseph, 1153 Park Ave.
 1913 Shea, John Francis, 144 Golden Hill
 1937 Shea, Richard O'Brien, 835 Washington Ave.
 1903 Smith, Edward Dorland, 881 Lafayette
 1935 Smith, Joseph Jacob, 1280 Stratfield Rd.
 1919 Smith, Stanton Reinhart, 144 Golden Hill
 1913 Smykowski, Bronislaw Louis, 405 Barnum Ave.
 1930 Sollosy, Alexander, 645 Bostwick Ave.
 1909 Sprague, Charles Harry, 29 Hanover
 1937 Strayer, Estella M., 955 Main
 1935 Strayer, Luther Milton, Jr., 955 Main
 1940 Tarasovic, Thomas Joseph, 49 Dover
 1920 Taylor, Clifton Clark, 881 Lafayette
 1938 Ter Kuile, Roger Couvelle, 881 Lafayette
 1925 Tolk, Nathan Robert, 558 Clinton Ave.
 1895 Tukey, Frank Martin, 144 Golden Hill
 1929 Turchick, Frank, 1831 Barnum Ave.
 1941 Tutles, Alexander James, 2180 Main
 1932 Uvitsky, Irving Harry, 3101 Main
 1941 Vioni, R. Edward, 842 North Ave.
 1923 Walsh, James Francis, 583 Noble Ave.
 1903 Warner, George Howell, 144 Golden Hill
 1920 Watts, Joseph Francis, 881 Lafayette
 1913 Weadon, William Lee, 144 Golden Hill
 1934 Wehger, Roland Theodore, 144 Golden Hill
 1922 Weise, Ellwood Carl, 144 Golden Hill
 1914 Weldon, Edwin Bernard, 144 Golden Hill
 1936 Yeager, Charles Frederick, 2139 E. Main
 1935 Zaur, Israel Sidney, 881 Lafayette
- BROOKFIELD CENTER
- 1939 Brewer, Francis
- DANBURY
- 1929 Amos, Isadore Louis, 317 Main
 1929 Booth, John Dibble, 173 Main
 1941 Brochu, Eugene Dalva, 229 Main
 1902 Bronson, William Thaddeus, 41 West
 1888 Brown, David Chester, 330 Main
 1928 Dclohery, Cornelius Leo, 215 Main
 1937 Eckert, George Robert, 394 Main
 1931 Gaffney, John James, 179 Main
 1931 Genovese, Frank Thomas, 172 White
 1938 Genovese, Serafino, 390 Main
 1930 Gibson, Donald Farnham, 75 West
 1929 Goldys, Frank Max, 209 Main
 1897 Gordon, William Francis, 26 West
 1940 Howard, Leonard Arnold, 87 West
 1912 Moore, Howard Delano, 203 Main
 1912 Mullins, Samuel Frederick, 116 Main
 1937 Murphy, James Joseph, 147 Main
 1939 Murray, Thomas Oscar, 145 Deer Hill Ave.
 1937 Rogol, Louis, 229 Main
 1926 Selleck, Nathaniel Benedict, 215 Main
 1913 Smith, Arthur Charles, 246 Main
 1920 Stahl, William Martin, 343 Main
 1907 Sunderland, Paul Ulysses, 160 Deer Hill Ave.
 1929 Sunderland, William Alexander, 158 Deer Hill Ave.
 1932 Tomaino, Felix Francis, 8 West
- DARIEN
- 1940 Ross, Allan Maxwell, 188 Post Rd.
 1938 Van Tassel, Walter, 194 Post Rd.
- FAIRFIELD
- 1939 Biehn, Donald M. Frick, 133 Reef Rd.
 1928 Biehn, Sidney Lister, 22 Reef Rd.
 1935 Davis, Thomas Francis, 703 Post Rd.
 1938 Fulstow, Marjorie, 1248 Post Rd.
 1940 Little, Mervyn Henry, 970 Old Post Rd.
 1932 Pitock, Morris Philip, 570 Post Rd.
- SOUTHPORT
- 1938 Mathews, Frank Pelletreau, Main

GREENWICH

- 1935 Amoss, Harold Lindsey, 21 Field Point Rd.
 1938 Carter, Gray, 29 Hillside Ave.
 1934 Clark, J. Bayard, 18 Field Point Rd.
 1904 Clarke, John Alexander, 92 Mason
 1933 Close, John Frederick, 66 Milbank Ave.
 1937 Gates, Aaron Billings, 305 Millbank Ave.
 1937 Hawthorne, Julian, Greenwich Towers
 1934 Hitchcock, Freeman St. Clair, 275 N. Maple Ave.
 1927 Knapp, Charles Stanley, 18 Field Point Rd.
 1918 Knapp, Charles Whittemore, 43 Maple Ave.
 1916 Knowlton, Donald Jerome, 36 Mason
 1940 Larimore, Louise D., Greenwich Hospital
 1933 Lockwood, Jane, 271 Lake Ave.
 1932 McCreery, John Alexander, 43 Maple Ave.
 1939 Reynolds, Whitman Mead, 53 Mason
 1935 Rogers, Robert Page, 111 North
 1938 Serrell, Howard P., 43 Maple Ave.
 1940 Shaw, Lillian Eloise, Ituri Towers
 1937 Thompson, Sidney Attilio, 161 Mason
 1940 Tiebout, Harry Morgan, Blythewood
 1934 Tinkess, Donald Fwing, Ituri Towers
 1939 Tunick, George L., 193 Mason
 1933 Vickers, James Leonard, 40 West Elm

COS COB

- 1940 Ayres, Payson Bryan, 10 Old Post Rd.
 1912 Bergin, Thomas Joseph, 2 Mead Ave.

OLD GREENWICH

- 1914 Austin, Albert Elmer, 13 Arcadia Rd.
 1926 Kaprielian, Haigazoon Kruger, 312 Sound Beach Ave.
 1936 Kelly, James Colman Francis, 282 Sound Beach Ave.
 1939 Read, Francis Arnold, 127 Sound Beach Ave.
 1929 Sheriak, Joseph V., 13 Arcadia Rd.

MONROE

STEPNEY DEPOT

- 1912 Wales, Francis Joseph

NEW CANAAN

- 1937 Abrahams, Meyer, 191 South
 1933 Bucciarelli, John Anthony, 93 East Ave.
 1939 Cammann, Oswald DeNormandie, 80 South Ave.
 1938 DuBois, Franklin Smith, Silver Hill
 1939 Frothingham, John Gerrish, 149 South Main
 1941 Hebard, George Whiting, 28 Elm
 1932 Lowsley, Oswald Swinney, "Twin Knolls," 29 Cherry
 1935 Ludlow, George Craig, 8 Oenoke Ave.
 1939 Mellroy, Patrick Thomas, 25 Church
 1908 O'Shaughnessy, Edmund Joseph, 29 Cherry
 1938 Selenger, Jerome, Elm
 1935 Terhune, William Barclay, Silver Hill
 1941 Twachtman, Eric, 201 Park
 1931 Wadsworth, Ruth Flanigen, Smith Ridge

NEWTOWN

- 1927 Desmond, Waldo Fairfield, Main
 1941 Friedman, Samuel, Fairfield State Hospital
 1940 Green, William Frederick, Fairfield State Hospital
 1935 Grout, Stillman Proctor, Fairfield State Hospital

- 1941 Kennedy, Robert Edward, Fairfield State Hospital
 1936 Moore, Clifford Douglas, Fairfield State Hospital
 1941 Oltman, Jane Elizabeth, Fairfield State Hospital
 1941 Rochlin, Gregory N., Fairfield State Hospital

SANDY HOOK

- 1937 Egee, J. Benton

NORWALK

- 1933 Chipman, Sidney Shaw, 520 West Ave.
 1937 Diamond, Edward H., 154 East Ave.
 1940 Fitzpatrick, Wesley Fenton, 85 East Ave.
 1938 Gorham, Grace Viola, 64 Wall
 1915 Kellogg, Henry Kirke White, 725 West Ave.
 1930 Miller, John, 711 West Ave., and 63 North St.,
 Greenwich
 1938 Northrop, Robert Arthur, 64 Wall
 1938 Padula, Ralph Domenick, 502 West Ave.
 1929 Patterson, Frederick Arthur, 520 West Ave.
 1938 Perdue, Robert E., 625 West Ave.
 1930 Perkins, Charles Winfield, 520 West Ave.
 1920 Perry, Mabelle Jeane, 676 West Ave.
 1938 Piasecki, Joseph L., 520 West Ave.
 1939 Scanlon, John Joseph, 276 West Ave.
 1928 Scanlon, Thomas Francis, 394 West Ave.
 1934 Stone, William Stephen, Chestnut Hill
 1929 Tracey, Edward John, 637 West Ave.
 1890 Tracey, William Joseph, 637 West Ave.
 1920 Tracey, William Wallace, 637 West Ave.
 1904 Turner, Arthur Robert, 701 West Ave.
 1938 Vollmer, John William, 654 West Ave.
 1934 Wallace, Victor George Henry, 463 West Ave. and
 1 Atlantic St., Stamford
 1938 Weinstein, Nathan, 463 West Ave.

SOUTH NORWALK

- 1936 Beck, Eugene Cornelius, 75 So. Main
 1918 Bradley, Theron Robert, 9 Washington
 1941 Cody, George Richard, 61 So. Main
 1938 Corridon, James Donald, 47 Seaview Ave.
 1922 Fawcett, George Gifford, 8 Washington
 1941 Flanagan, Edwin Daniel, 141 West Ave.
 1938 Giuliano, Louis Augustine, 111 West Ave.
 1941 Green, H. Howard, 75 So. Main.
 1940 Heafey, John Robert, 3 Washington
 1938 Hunkemeir, Edna, 75 So. Main
 1923 McMahon, William Henry, Jr., 13 Washington
 1938 Paris, Marcus, 64 So. Main
 1941 Rosenthal, Isidor, 72 So. Main
 1896 Sherer, Henry Clifford, 1 Washington
 1931 Simon, Louis Goodwin, 59 South Main
 1937 Stietzel, Eric Ernst, 19 Franklin
 1939 Zweben, Albert, 74 South Main

REDDING

- 1941 Grevatt, Kenneth Lloyd

RIDGEFIELD

- 1937 Bell, Joseph Sloane, 54 Main
 1926 Lowe, Russell Walter, 126 Main
 1927 Woodford, Francis Bowditch, 62 Main

SHELTON

- 1939 Edson, Ralph Howard, 77 Oak Ave.
 1917 Finn, Edward James, 452 Howe Ave.
 1930 Gaetz, Thomas Harold, "Laurel Heights"
 1937 Howlett, Kirby Smith, Jr., "Laurel Heights"
 1925 Lynch, Edward James, "Laurel Heights"
 1941 Pagliaro, Joseph John, 476 Howe Ave.
 1895 Randall, William Sherman, 241 Coram Ave.
 1941 Reid, Lee Rhodes, "Laurel Heights"
 1938 Rilance, Arnold Boon, "Laurel Heights"

STAMFORD

- 1937 Awdziejewicz, Francis Joseph, 295 Atlantic
 1936 Bannon, Frederick Michael, 65 South
 1907 Barnes, Frank Haslehurst, Dr. Barnes Sanitarium
 1927 Bissell, Addison Hayes, 65 South
 1926 Bowman, Stuart Howard, 58 South
 1940 Bria, William Francis, 25 Bedford
 1928 Brown, Paul Henningway, 52 South
 1935 Carpenter, Robert Morse, 636 Summer
 1937 Carwin, Joseph Lucian, Jr., 115 West Main
 1940 Cagnetta, James John, 366 Atlantic
 1940 Connolly, Joseph Patrick, 79 Warren
 1937 Costanzo, James Joseph, 58 South
 1940 Crane, James Everett, 50 Glenbrook Rd.
 1909 Crane, Ralph William, 50 Glenbrook Rd.
 1937 Cunningham, Robert D. M., 1 Atlantic
 1934 D'Andrea, Frank Henry, 29 South
 1938 Dean, Stanley Rochelle, 31 Third
 1909 Dichter, Charles Levi, 33 Forest
 1935 Dichter, Irving Samuel, 65 Broad
 1937 Dorion, Robinson Harry, 449 Atlantic
 1933 Fincke, Charles Louis, 1 Atlantic
 1937 Fine, Barnet, 49 Grove
 1936 Fine, Joseph, 96 Main
 1931 Fiske, Madeline, 29 Suburban Ave.
 1934 Friedberg, Solomon, 21 Forest
 1931 Gandy, Raymond Alfred, 57 Broad
 1913 Gandy, Raymond Reeves, 57 Broad
 1931 Giles, Newell Walton, 1 Atlantic
 1909 Godfrey, William Truitt, 65 South
 1941 Grady, Joseph Francis, 65 South
 1929 Hamilton, John Stewart Marshall, 88 South
 1937 Harrison, Francis Murphy, 512 Atlantic
 1908 Harrison, John Francis, 512 Atlantic
 1916 Henderson, Alfred Collard, 55 Glenbrook Rd.
 1935 Henderson, Jean, 55 Glenbrook Rd.
 1901 Hertzberg, George Robert Reinhold, 40 South
 1930 Hertzberg, Reinhold Frederick, 227 Bedford
 1937 Hopper, Edward Bernard, 58 South
 1937 Hymovich, Leo, 74 Park Pl.
 1929 Keddy, Russell Alfred, Stamford Hospital
 1938 Kezel, Albert Patrick C., 23 Atlantic
 1939 Koffler, Arthur, 71 River
 1934 Malloy, Edward Francis, 65 South
 1933 McFarland, Frederick William, 65 South
 1928 McGourty, Andrew Frederick, 7 Glenbrook Rd.
 1935 McGourty, David Philip, 25 Bedford
 1924 McMahan, Francis Cash, 62 Suburban Ave.
 1934 Meade, Charles Havelock Beverly, 433 Atlantic
 1930 Meschter, Eugene Funk, Yale & Towne Co.

- 1938 Murphy, Charles Anthony, 65 South
 1931 Murray, Henry Joseph, 53 South
 1940 Nemoitin, Bernard Oscar, 96 Main
 1911 Nemoitin, Jacob, 96 Main
 1928 Paul, Voyle Abrams, 58 South
 1938 Rawls, Edward Cotton, 1 Atlantic
 1929 Resnik, William Harry, 65 South
 1936 Rose, Samuel Allison, 25 Bedford
 1937 Rowell, Edward Everett, 104 South
 1929 Rynard, William Morvel Wesley, 29 South
 1932 Schmidt, Norman Louis, 58 South
 1930 Sette, Alfred Joseph, 308 Atlantic
 1938 Sherman, Saul Harvey, 81 Bedford
 1909 Shirk, Samuel Martin, 218 Bedford
 1936 Shockley, Francis Milton, Stamford Hall
 1941 Smith, Leo Michael, 449 Atlantic
 1917 Smith, William Earl, 65 South
 1934 Starrett, Jay Ellis, 885 Summer
 1907 Staub, John Howard, 100 South
 1931 Stone, Merlin Jones, 76 Glenbrook Rd., also 161
 Mason, Greenwich
 1920 Stringfield, Oliver Linwood, 1416 Bedford
 1940 Swarts, William B., 1 Atlantic
 1937 Throckmorton, Verl John, Stamford Trust Bldg.
 1940 Troy, William Daniel, 3 St. George Ave.
 1931 Turnley, William Henry, 1 Atlantic
 1934 Turton, Effie Howe, 90 Prospect
 1939 Washburn, Wendell James, 65 South and 261 Lake
 Ave., Greenwich
 1937 Weaver, Bruce Stevens, 77 South
 1928 White, William Beverly, 322 Main

GLENBROOK

- 1938 O'Meara, Francis Patrick, 1 Elm Pl.
 1885 Phillips, Alfred Noroton, Middlesex Rd.

RIVERSIDE

- 1940 Adams, Mary, Arnistrong Ave.

STRATFORD

- 1938 Ashcroft, Allan Davis, 3585 Main
 1938 Findorak, Francis George, 1882 Barnum Ave.
 1936 Friedman, Nathan Harris, 891 E. Broadway
 1927 Haberlin, Chester Edward, 2921 Main
 1924 Heidger, Luther Caldwell, 972 E. Broadway
 1929 Hennessey, Edward Henry Joseph, 2390 Main
 1939 Levy, Samuel Howard, 2528 Main
 1934 Maher, John Rodden, 2184 Main
 1931 Oesau, Harold Thomas, 1949 Main
 1940 Penner, Sidney Lincoln, 2692 Main

TRUMBULL

LONG HILL

- 1912 Smith, George Arthur

WESTPORT

- 1904 Bill, Philip Worcester, 40 Thomas Rd.
 1930 Ellrich, David Lionel, 125 E. State
 1941 Kelsey, Weston Maynard, So. Compo Rd.
 1934 Morgan, William Oliver, 193 Main
 1927 Munson, William Russell, 20 Church Lane
 1937 Nespor, Robert Venzel, 89 Main
 1925 Phillips, Harry Shaw, 44 E. Church

- 1941 Pratt, George Kenneth, 80 Myrtle Ave.
 1936 Teuscher, William Philip, 18 Compo Rd.

GREENS FARMS

- 1934 Smith, Stephen Munro, Box 31

WILTON

- 1939 Knauth, Marjorie Strauss, Drum Hill Rd.

OUT OF COUNTY

- 1925 Cohen, Joseph, 928 Edgewood Ave., Trenton, N. J.
 1937 Craighill, Margaret D., Women's Medical College of
 Pennsylvania, Henry Ave. and Abbottsford Rd.,
 Philadelphia, Penna.
 1939 Ireland, Richard Milton, 66 Bridge, New Milford
 1939 Keating, John Joseph, 20 So. Main, New Milford
 1939 Lynn, John Gallaway, 735 West 172nd, N. Y. C.
 1933 Maddren, William Harvey, 126 Pine, Freeport, L. I.
 1907 Pratt, Nathan Tolles, Old Saybrook
 1929 Salmond, Paul H., Richmond State Hospital, Rich-
 mond, Indiana
 1939 Simses, John Peter, 1147 15th, St., N. W., Washington,
 D. C.
 1937 Strobel, Joseph E., The Seaside, Waterford

HARTFORD COUNTY ASSOCIATION

President: THACHER W. WORTHEN, 179 Allyn St., Hartford
Vice-President: WILLIAM R. HANRAHAN, 209 Center St.,
 Bristol

Secretary-Treasurer: FRANK T. OBERG, 50 Farmington Ave.,
 Hartford

Councilor: ARTHUR B. LANDRY, 50 Farmington Ave., Hartford
Business Office: 38 Prospect St., Hartford

Annual Meeting, First Tuesday in April
 Semi-Annual Meeting, Fourth Tuesday in October

BERLIN

- 1908 Hodgson, Thomas Cady, Worthington Ridge

KENSINGTON

- 1938 Lo Vetere, Angelo Arthur, 528 Farmington

BLOOMFIELD

- 1936 Burgdorf, Alfred Louis, Duncaster Rd.

BRISTOL

- 1930 Appell, Paul Harry, 227 Main
 1934 Beatrice, Alphonse Anthony, 331 Main
 1936 Bird, Frederick Stanford, 9 N. Main
 1932 Borkowski, Boleslaus Joseph, 4 School
 1900 Brackett, Arthur Stone, 321 Main
 1934 Donohue, Bartholomew Francis, 481 N. Main
 1935 Flynn, William Henry, 9 N. Main
 1925 Gore, Michael Alvord, 321 Main
 1937 Hall, Martin Irving, 214 Belridge Rd.
 1921 Hanrahan, William Richard, 209 Center
 1938 Hudon, Frederick Alfred, 321 Main
 1939 Labuz, Eugene Frank, 342 Main
 1928 LaPlume, Albert Antonio, 218 West
 1929 Nestos, Peter Alexander, 63 Main
 1935 Papa, John Smith, 124 Main
 1921 Park, Paul Archibald, 133 Main

- 1921 Richardson, Ralph Augustus, 4 School
 1922 Robbins, Benjamin Bissell, 47 Main
 1935 Siliciano, Raoul Andrew Victorius, 110 South
 1936 Stevenson, William Robb, 7 Prospect
 1939 Tirella, Fred Francis, 481 N. Main
 1909 Whipple, Benedict Nolasco, 45 N. Main
 1934 Winters, Herman W., 405 N. Main

CANTON

COLLINSVILLE

- 1906 Cox, Ralph Benjamin

EAST HARTFORD

- 1931 Brecker, Francis Wellington, 9 Burnside Ave.
 1936 Gallivan, John Norman, 74 Connecticut Blvd.
 1927 Goddard, Harvey Burton, 970 Main
 1923 Haylett, Howard Bulkeley, 1109 Main
 1933 Houle, Raymond Theodore, 1010 Main
 1934 Lublin, Raymond David, 759 Main
 1937 McCue, Martin Patrick, 1429 Main
 1939 Mirabile, Thomas Joseph, 59 Burnside Ave.
 1916 Onderdonk, Harrie Jay, 61 Richard Rd.

EAST WINDSOR

BROAD BROOK

- 1923 Robinson, Wilfred John Thomas, Main
 1937 Maslak, Rudolph, South Main, Warehouse Point

ENFIELD

HAZARDVILLE

- 1906 Bridge, John Law, P. O. Box 272
 1923 Shepard, William Gordon, Main

THOMPSONVILLE

- 1937 Bloom, David Irving, 134 Pearl
 1937 Dignam, Bernard Stephen, 133 Pearl
 1906 Dowd, Michael Joseph, 25 Church
 1932 Fancher, Henry Wilson, 1070 Enfield
 1938 Gourlie, Howard Wallace, 53 New King
 1932 McHugh, John Francis, 29 Central
 1916 Simonton, Frank Forester, 75 N. Main
 1928 Stein, Albert, 144 Pearl
 1917 Vail, Thornton Edwin, 124 Main
 1940 Valenski, Thaddeus James, Main

FARMINGTON

- 1933 Bunnell, Walls Willard, Main
 1933 Ellis, Francis Dufty, Jr., Elm Tree Inn
 1939 Ewell, John Woodruff, Farmington

GLASTONBURY

- 1933 Earle, Benjamin Baylis, 2458 Main
 1935 Griswold, Edwin Monroe, 28 Ripley Rd.
 1939 Raffa, Joseph, 2638 Main
 1924 Whittles, Lee Jay, 2205 Main

SOUTH GLASTONBURY

- 1908 Ward, James, 972 Main

GRANBY

- 1923 Pendleton, Ernest Raymond

HARTFORD

- 1927 Allen, Wilmar Mason, 20 S. Hudson
 1937 Andrews, Egbert Morrill, 648 Asylum

- 1935 Angus, Leslie Robert, 200 Retreat Ave.
 1927 Antupit, Louis, 242 Trumbull
 1936 Apter, Harry, 1453 Main
 1932 Arons, Milton Robert, 1061 Albany Ave.
 1904 Backus, Harold Simeon, 99 Pratt
 1934 Bailey, Harry, 242 Trumbull
 1913 Bailey, Neil Herbert, 550 Main
 1923 Bancroft, Harold Arthur, 179 Allyn
 1940 Barker, Norman J., 55 Elm
 1933 Bausch, Carl Philipp, 36 Pearl
 1886 Beach, Charles Coffing, 54 Woodland
 1907 Beach, Charles Thomas, 50 Farmington Ave.
 1929 Beatman, Israel, 650 Main
 1934 Beizer, Edmund, 1711 Park
 1923 Bestor, Eugene Leonard, 36 Pearl
 1926 Bidgood, Charles Young, 179 Allyn
 1936 Bingham, Charles Tiffany, 751 Asylum Ave.
 1913 Biram, James Harrington, c/o Colt's Patent Fire Arms
 Mfg. Company, 17 Van Dyke Ave.
 1938 Birge, Henry L., 179 Allyn
 1907 Blair, Edward Holden, 43 Farmington Ave.
 1897 Botsford, Charles Porter, 219 Collins
 1903 Brainard, Clifford Brewster, 50 Farmington Ave.
 1916 Branon, Anthony William, 179 Allyn
 1912 Brayton, Howard Wheaton, 179 Allyn
 1939 Brennan, Edward L., 200 Retreat Ave.
 1931 Brewer, Timothy Francis, 211 Church
 1929 Buck, Burdette Jay, 50 Farmington Ave.
 1931 Buckley, Richard Cotter, 683 Asylum Ave.
 1932 Burlingame, Clarence Charles, 200 Retreat Ave.
 1937 Burns, Maudie Marie, 165 Capitol Ave.
 1928 Butler, Nicholas George, 50 Farmington Ave.
 1930 Byrne, David Walter, 179 Allyn
 1931 Calverley, Eleanor Jane Taylor, 143 Sigourney
 1914 Cantarow, Daniel, 10 Garden
 1934 Cappiello, Silvestro, 97 Vine
 1933 Carey, Thomas Cornelius, 50 Farmington Ave.
 1931 Carniglia, Ettore Francis, 50 Farmington Ave.
 1929 Carroll, James Edward, 220 Farmington Ave.
 1915 Carter, Earle Buell, 99 Pratt
 1930 Caulfield, Ernest Joseph, 683 Asylum Ave.
 1933 Cenci, Vincent Peter, 242 Trumbull
 1940 Clancy, John James, 179 Allyn
 1935 Clarke, Ralph deBallard, Cedarcrest
 1922 Clason, Freeman Pell, 179 Allyn
 1937 Clifford, Martha Louise, 165 Capitol Ave.
 1931 Climan, Max, 242 Trumbull
 1896 Cochran, Levi Bennett, 50 Farmington Ave.
 1928 Cogan, George Eugene, 50 Farmington Ave.
 1940 Cogland, John Lee, 550 Main
 1913 Cogswell, Eliot Sanborn, 179 Allyn
 1936 Cogswell, Lawrence Perley, 50 Farmington Ave.
 1938 Cohn, Samuel Hills, 235 Cornwall
 1935 Connor, Joseph Joyce, 750 Main
 1933 Corcoran, Michael Anthony, 37 Webster
 1913 Costello, Henry Nicholas, 134 Beacon
 1924 Couch, Arthur Rockwell, 95 Farmington Ave.
 1921 Cragin, Donald Brett, 151 Farmington Ave.
 1933 Crosby, Edward Harding, 50 Farmington Ave.
 1936 Cunningham, James Morrow, 165 Capitol Ave.
 1938 Curtis, Burr Harding, 4 Atwood
 1914 Daly, Charles William, 750 Main
 1935 Daly, William Patrick, 342 Edgewood
 1929 Davenport, Anna Keith Prentiss, 54 Church
 1932 Dawson, Lionel Montrose, 700 Main
 1909 DeBonis, Domencio A., 183 Westland
 1914 Deming, Clinton Demas, 179 Allyn
 1914 Deming, Edward Adams, 715 Asylum Ave.
 1931 DePasquale, Francis Lawrence, 1026 Main
 1937 DePasquale, John Anthony, 381 W. Preston
 1934 DeVito, Michael Joseph, 525 Main
 1930 Dignam, Edward Anthony, 750 Main
 1921 Dinsmore, William Wirt, 700 Main
 1931 Dion, Asa Joseph, 207 Washington
 1939 Dodd, Burwell, 689 Asylum
 1934 Donner, Samuel, 99 Pratt
 1938 Donovan, William Francis, 47 Main
 1937 Duffy, Leo Thomas, 214 Franklin Ave.
 1923 Dunne, Richard Edwin, 30 Farmington Ave.
 1938 Durkee, Ralph Everett, Jr., 179 Allyn
 1916 Dwyer, William, 18 Asylum
 1927 Elliot, K. Gregory, 631 Park
 1937 Ellison, Frederick Speirs, 50 Farmington Ave.
 1895 Elmer, Edward Oliver, 1731 Park
 1914 Emmett, Francis Arthur, 410 Asylum
 1937 Fagan, Francis Xavier, 68 Pratt
 1933 Farland, Victor Louis, 54 Pratt
 1919 Fay, William James, 179 Allyn
 1929 Felty, Augustus R., 846 Asylum Ave.
 1934 Finley, George Clark, 50 Farmington Ave.
 1913 Flaherty, Claude Vincent, 50 Farmington Ave.
 1931 Friery, Clarence Milton, 110 Greenfield
 1919 Furniss, Henry Watson, 1335 Main
 1927 Gaberman, David, 179 Allyn
 1937 Galinsky, David, 780 Wethersfield Ave.
 1921 Garland, Robert Bernard, 689 Asylum Ave.
 1898 Gill, Michael Henry, 36 Pearl
 1941 Gillespie, Harry, 983 Main
 1922 Gills, William Lee, 179 Allyn
 1934 Giorgio, Nicholas Anthony, 61 Edwards
 1937 Giuliano, Sebastian, 468 Franklin Ave.
 1935 Glass, George Courtenay, 476 Farmington Ave.
 1934 Glaubman, Henry Mitchell, 20 Lenox
 1927 Goff, Charles Weer, 30 Farmington Ave.
 1936 Gold, Louis Henry, 412 Farmington Ave.
 1930 Goldenberg, Jacob Joseph, 832 Albany Ave.
 1933 Goodell, Robert Alvan, 79 Elm
 1900 Goodrich, Charles Augustus, 5 Haynes
 1919 Gosselin, George Adelor, 50 Farmington Ave.
 1935 Gould, Max Martin, 434 Main
 1923 Grau, Leroy Charles, 700 Main
 1924 Griswold, Matthew Hammond, 165 Capitol Ave.
 1941 Grossman, Walter, 750 Main
 1921 Grosvenor, Frank Livingston, 700 Main
 1941 Gudger, James Roby, 140 Garden
 1930 Hall, Llewellyn, 79 Elm
 1939 Hall, Wendell Charles, 179 Allyn
 1938 Harris, Louis David, 242 Trumbull
 1936 Harvey, Daniel Foster, 218 No. Beacon
 1930 Hastings, Louis Pease, 370 Collins
 1908 Hatheway, Clarence Morris, 110 High
 1937 Hazen, Donald Robert, 179 Allyn

- 1931 Hennessy, James Joseph, Cedarcrest
 1907 Hepburn, Thomas Norval, 179 Allyn
 1940 Heublein, Gilbert Whipple, 179 Allyn
 1930 Heyman, Joseph, 650 Main
 1941 Hickcox, Curtis Bronson, 20 S. Hudson
 1934 Hirschfeld, Otto Max, 1037 Albany Ave.
 1931 Hirshberg, Manuel Shelton, 650 Main
 1925 Hoffman, Charles Curtis, 700 Main
 1924 Hogan, Walter Louis, 750 Main
 1929 Holt, Kerchival Rogers, 50 Farmington Ave.
 1930 Holtz, Raymond Sidney, 242 Trumbull
 1935 Hough, Perry Tyler, 179 Beacon
 1922 Howe, Glover Elbridge, 179 Allyn
 1936 Hurwitz, George Hillel, 75 Pearl
 1920 Hurwitz, Herman Max, 75 Pearl
 1917 Hutchinson, James Elder, 125 Trumbull
 1938 Hutton, Gordon Hobbs, 200 Retreat Ave.
 1937 Irving, James Grant, 151 Farmington Ave.
 1939 Jackson, Allen Francis, 2137 Main
 1934 James, Lewis Paul, 68 Pratt
 1912 Jarvis, Henry Gildersleeve, 179 Allyn
 1940 Jenovese, Joseph Francis, 179 Allyn
 1930 Jones, Frank Stafford, 179 Allyn
 1928 Kalin, Jacob Isaac, 286 Church
 1933 Kardys, John Albert, 487 Main
 1935 Karotkin, Robert Harold, 816 Albany Ave.
 1935 Kaschmann, Joseph, 42 Asylum
 1937 Katz, Dewey, 99 Pratt
 1924 Katz, Henry, 750 Main
 1926 Keefe, George Gregory, 30 Sisson Ave.
 1934 Keefe, Raymond Starkey, 272 Franklin Ave.
 1934 Keefe, Walter Joseph, 30 Sisson Ave.
 1908 Keith, Albert Russell, 50 Farmington Ave.
 1920 Kelly, Claude Currie, 179 Allyn
 1930 Kendall, Ralph Emerson, 20 S. Hudson
 1927 Kilbourn, Austin, 580 Asylum
 1920 Kilbourn, Joseph Birney, 36 Pearl
 1906 Kingsbury, Isaac William, 125 Trumbull
 1937 Klieman, Abraham Ober, 750 Main
 1932 Klein, Abraham Arthur, 509 Farmington Ave.
 1925 Knowlton, Millard, 165 Capitol Ave.
 1930 Kunkel, Frederick Earle, 179 Allyn
 1941 Lamoureux, Eugene Edward, 165 Capitol Ave.
 1901 Lampson, Edward Rutledge, 179 Allyn
 1938 Lampson, Rutledge Starr, 179 Allyn
 1913 Landry, Arthur Bernard, 50 Farmington Ave.
 1926 Landry, Benedict Bernard, 50 Farmington Ave.
 1940 Lankin, Joseph John, 525 Main
 1929 Larrabee, John Whitfield, 650 Main
 1895 Lawton, Franklin Lyman, 580 Farmington Ave.
 1920 Leichner, William, 66 Farmington Ave.
 1933 Levin, Albert Elliott, 242 Trumbull
 1935 Levine, Sinclair Simcha, 54 Church
 1936 Lewis, Samuel Donald, 49 Pearl
 1937 Lischner, Moses David, 650 Main
 1934 Little, Milton Frederick, 49 Pearl
 1915 Locke, Harry Leslie Franklin, 179 Allyn
 1923 Luby, Thomas John, 410 Asylum
 1913 Madden, Leon Irving, 50 Farmington Ave.
 1919 Maislen, Samuel, 2138 Main
 1931 Mancoll, Morris Max, 242 Trumbull
 1932 Maranzini, Samuel, 763 Albany Ave.
 1930 McClellan, Wilbert Ernest, 75 Pearl
 1898 McCook, John Butler, 390 Main
 1936 McCormack, Christopher Joseph, 50 Farmington Ave.
 1938 McCrann, Donald Joseph, 50 Farmington Ave.
 1934 McDermott, John Francis, 750 Main
 1933 McGrath, John Francis, 663 Maple Ave.
 1934 McLean, John Joseph, 650 Main
 1932 McLellan, Philip Garretson, 683 Asylum Ave.
 1935 McNulty, Terence Francis, 21 Sisson Ave.
 1907 McPartland, Patrick Farrell, 410 Asylum
 1916 McPherson, Sidney Horace, 4 Atwood
 1933 Middlebrook, Louis Francis, Jr., 689 Asylum Ave.
 1941 Mikolainis, Mindaugis Vincent, St. Francis Hospital
 1916 Miller, James Raglan, 179 Allyn
 1933 Mirabile, Charles Samuel, 179 Allyn
 1938 Montano, Charles Carl, 525 Main
 1937 Montano, Rocco Anthony, 242 Trumbull
 1909 Morrissey, Michael Joseph, 18 Asylum
 1934 Morse, Lyman Rogers, Cedarcrest
 1939 Moxness, Bennie Arthur, 165 Capitol Ave.
 1927 Moylan, Thomas Patrick, 50 Farmington Ave.
 1930 Moyle, Henry Brown, 488 Main
 1935 Murphy, Thomas Francis, 619 Park
 1897 Naylor, James Henry, 1 Main
 1938 Neidlinger, William James, 751 Asylum Ave.
 1926 Oberg, Frank Thorwald, 50 Farmington Ave.
 1923 O'Connell, John Francis, 865 Park
 1928 O'Connell, Maurice Francis, 50 Farmington Ave.
 1902 O'Flaherty, Ellen Pembroke, 140 Main
 1928 Ogden, Ralph Trafton, 179 Allyn
 1931 Olmstead, John Gerald Maurice, 404 Farmington Ave.
 1938 O'Malley, Martha Alice, 165 Capitol Ave.
 1937 O'Neil, Charles William, 18 Asylum
 1921 Osborn, Stanley Hart, 165 Capitol Ave.
 1927 Osmond, Robert Hunter, 50 Farmington Ave.
 1938 Padula, Vincent Domenica, 1210 Broad
 1933 Paladino, Joseph Salvator, 300 Franklin Ave.
 1919 Parker, John Woodcock, 84 Forest
 1926 Partridge, Winthrop Prescott, 403 Farmington Ave.
 1938 Peacock, Albert Upham, 751 Asylum Ave.
 1933 Phelps, Maxwell Overlock, 594 Farmington Ave.
 1937 Phelps, Paul Stetson, State Tuberculosis Commission,
 165 Capitol Ave.
 1939 Phillips, Paul Lange, 333 Washington Ave.
 1929 Pike, Maurice Mitchell, 179 Allyn
 1934 Preston, Thomas Raymond, 65 Kenyon
 1934 Priddy, Foster Eugene, 30 Farmington Ave.
 1936 Quarrier, Sidney Sayre, 751 Asylum Ave.
 1923 Radin, Morris Jacob, 650 Main
 1928 Radom, Myron Michael, 242 Trumbull
 1923 Rankin, Bertrand Fred, 57 Pratt
 1913 Reardon, William Francis, 750 Main
 1934 Reidy, David Dillon, 750 Main
 1927 Resnisky, Andrew Francis, 57 Pratt
 1928 Reynolds, Harry St. Clair, 410 Asylum
 1916 Reynolds, Harry Stephen, 18 Asylum
 1930 Reynolds, Robert Gardner, 179 Allyn
 1922 Roberts, Douglas James, 179 Allyn
 1932 Robinson, Albert James, 55 Elm
 1940 Roche, Arthur F., 50 Farmington Ave.

- 1934 Rollins, Henry Brock, 140 Garden
 1932 Romaniello, Rocco John, 415 Hillside Ave.
 1909 Rooney, James Francis, 410 Asylum
 1936 Rosenbaum, George Jonas, 647 New Britain Ave.
 1938 Rosenthal, Ernest, 18 Asylum
 1935 Roth, Frank Edward, 650 Main
 1907 Rowley, Robert Lee, 79 Elm
 1921 Russell, George Gardiner, 179 Allyn
 1936 Ryan, Francis James, 63 Webster
 1926 Salvin, Benjamin Lloyd, 242 Trumbull
 1932 Samponaro, Nicholas, 650 Main
 1937 Sayers, John Joseph, 656 Park
 1923 St. John, Leopold Albert, 25 Charter Oak Ave.
 1928 Scafarello, Peter Joseph, 410 Asylum
 1932 Schaefer, Abraham Maurice, 262 Maple Ave.
 1920 Schaefer, Jacob, 137 N. Whitney
 1934 Schuman, David Harold, 909 Albany Ave.
 1940 Scoville, William Beecher, 179 Allyn
 1923 Scudder, Winthrop Davis, 179 Allyn
 1887 Segur, Gideon Cross, 67 Farmington Ave.
 1932 Seibert, Alfred Frank, 700 Main
 1920 Shafer, Alexander Samuel, 68 Pratt
 1928 Shaw, George Hammil, 700 Main
 1920 Shea, Daniel Edward, 137 N. Whitney
 1933 Shulman, David Nathaniel, 422 Farmington Ave.
 1940 Shupis, Anthony, Jr., 444 Park
 1932 Sigal, Jacob Bernard, 99 Pratt
 1936 Slossburg, David Seymour, 541 Park
 1925 Smith, George Mortimer, 700 Main
 1939 Smith, Wilson Fitch, 50 Farmington Ave.
 1937 Sneidman, George Irving, 18 Asylum
 1929 Snelling, Pinckney Welch, 179 Allyn
 1938 Souther, Susan Page, State Office Building
 1937 Spekter, Louis, 165 Capitol Ave.
 1921 Spillane, Bernard, 30 Farmington Ave.
 1927 Standish, Erland Myles, 179 Allyn
 1897 Standish, James Herbert, 665 Asylum Ave.
 1931 Standish, Welles Adams, 665 Asylum Ave.
 1905 Starr, Robert Sythoff, 179 Allyn
 1930 Steincrohn, Peter Joseph, 705 Asylum Ave.
 1902 Steiner, Walter Ralph, 646 Asylum Ave.
 1930 Stephenson, Charles Wattles, 179 Allyn
 1938 Stolzheise, Ralph Merwin, 200 Retreat Ave.
 1903 Storrs, Eckley Raynor, 179 Allyn
 1923 Storrs, Ralph Warren, 179 Allyn
 1923 Stoughton, Dwight Harold, 247 S. Whitney
 1908 Swan, Horace Cheney, Trinity College
 1914 Sweet, John Henry Throop, Jr., 179 Allyn
 1905 Swett, Paul Plummer, 4 Atwood
 1932 Talbot, Henry Pierce, 165 Capitol Ave.
 1930 Taylor, Andrew, 179 Allyn
 1906 Taylor, Maude Winifred, 914 Asylum Ave.
 1921 Thenebe, Carl Leonard, 68 Pratt
 1922 Thompson, Hartwell Greene, 179 Allyn
 1938 Tonken, Louis Clarence, 485 Farmington Ave.
 1938 Tovell, Ralph Moore, 20 S. Hudson
 1930 Townsend, Wilmot Charles, 50 Farmington Ave.
 1912 Truex, Edward Hamilton, 99 Pratt
 1908 Tuch, Morris, 99 Pratt
 1907 Turbert, Edward Joseph, 703 Asylum Ave.
 1937 Twaddle, Paul Holmes, 179 Allyn
 1937 Unsworth, Arthur Charles, 49 Pearl
 1933 Urrichio, Joseph George, 260 Wethersfield Ave.
 1908 Vail, George Francis, 36 Pearl
 1923 VanKleeck, Euen, 700 Main
 1904 VanStrander, William Harold, 179 Church
 1926 VanWart, William Haley, 650 Main
 1917 Vernlund, Carl Frithiof, 179 Allyn
 1921 Vershbow, Nathan, 28 Sisson Ave.
 1914 Waite, Robert Lester, 68 Pratt
 1932 Wallace, Charles Kenneth, 700 Main
 1937 Walton, Loftus Linwood, 179 Allyn
 1932 Warring, Howard Lewis, 1756 Main
 1934 Weiner, Julius Gills, 750 Main
 1931 Weisenfeld, Nathan, 169 Church
 1936 Weissenborn, Walter, 50 Farmington Ave.
 1907 Welch, Thomas Francis, 50 Farmington Ave.
 1920 Weld, Stanley Burnham, 179 Allyn
 1916 Wells, Donald Breckinridge, 580 Asylum
 1922 Wentworth, John Alexander, 50 Farmington Ave.
 1924 Whalen, Edward Joseph, 750 Main
 1938 White, Benjamin Vroom, 179 Allyn
 1907 Wiedman, Otto George, 179 Allyn
 1931 Wienski, John Casimer, 502 Park
 1935 Wilson, Charles Cristopher, 249 High
 1907 Wilson, James Cornelius, 179 Allyn
 1930 Wilson, William Augustus, 683 Asylum Ave.
 1904 Witter, Orin Russell, 179 Allyn
 1933 Wood, Frank Oliver, 404 Farmington Ave.
 1934 Woodford, Chester North, 703 Asylum Ave.
 1916 Worthen, Thacher Washburn, 179 Allyn
 1922 Wright, William Witter, 700 Main
 1932 Wulp, George Adolf, 50 Farmington Ave.
 1912 Yergason, Robert Moseley, 50 Farmington Ave.
 1938 Young, William Greenhill, 200 Retreat Ave.
 1928 Zariphes, Constantine Argyros Paleslogos, 96 Main
 1934 Zeman, Burnhardt, 1269 Main
- ### MANCHESTER
- 1931 Aiken, Sidney, 489 Main
 1924 Boyd, Howard, 935 Main
 1939 Conlon, William Linas, 15 Main
 1940 Diskan, Albert Elmer, 869 Main
 1936 Keeney, Robert Raymond, Jr., 791 Main
 1925 Knapp, Robert Phineas, 147 Hartford Rd.
 1937 Sundquist, Alfred Bernhardt, 843 Main
 1936 Zaglio, Edmond Robert, 12 Myrtle
- ### SOUTH MANCHESTER
- 1926 Caldwell, David Manchester, 935 Main
 1926 Friend, Amos Edgar, 935 Main
 1927 Higgins, Edwin Carlton, 875 Main
 1921 Lundberg, George Albin Ferdinand, 755 Main
 1916 Moore, Demarquis DeCasso Ye Rujo, 689 Main
 1930 Moriarty, Mortimer Emmett, 905 Main
- ### NEW BRITAIN
- 1932 Benoit, Raoul Joseph, 272 Main
 1934 Bernstein, Dwight J., 55 West Main
 1930 Blogoslawski, Walter Joseph, 419 Main
 1909 Bodley, George Houghton, 155 W. Main
 1935 Bristoll, Donald Andrews, 55 W. Main
 1940 Buccheri, Francis Salvatore, 419 Main

- 1927 Buol, Robert Stanley, 99 W. Main
 1935 Chalmers, Harriet Elizabeth, 45 Walnut
 1926 Chernaik, Samuel Julius, 300 Main
 1913 Cooley, Clifton Mather, 44 S. High
 1939 Daley, Louis William, 99 W. Main
 1938 Dalton, George Henry, 99 W. Main
 1931 Darrow, John Edward, 55 W. Main
 1928 Donnelly, Stephen Patrick, 55 W. Main
 1934 Dray, Edward Joseph, 259 Main
 1915 Dunn, George Washington, 55 W. Main
 1936 Enander, Fred Conrad, 25 Arch
 1923 Flanagan, William Francis, 55 W. Main
 1931 Geeter, Isadore Stolper, 92 Grand
 1941 Goldschmidt, Myer, 300 Main
 1921 Grant, Arthur Sheldon, 55 W. Main
 1937 Hart, Carl Jay, 259 Main
 1930 Kalett, Joseph, 99 W. Main
 1924 Kinsella, Michael Allen, 52 Main
 1926 Lekston, Roman Francis, 197 W. Main
 1930 Matteis, Joseph Theodore, 55 W. Main
 1939 McMahon, George William, 272 Main
 1934 Michalowski, Valerian Stanislaus, 561 Main
 1937 Miller, Harry Bernard, 81 W. Main
 1935 Moorad, Philip Jacob, 55 W. Main
 1912 Morrissey, William Thomas, 55 W. Main
 1923 Mouradian, Marion Garoudy, 87 Prospect
 1940 Nevulis, Anthony Victor, 140 Main
 1938 Orbach, Egmont Julius, 81 W. Main
 1939 Paolillo, Charles Gerald, 99 W. Main
 1938 Parlato, Harry Anthony, 99 W. Main
 1938 Perakos, George Peter, 300 Main
 1939 Pola, William Edward, 99 W. Main
 1930 Pullen, Richard Woollard, 55 W. Main
 1930 Purney, John, 99 W. Main
 1936 Resnik, Edward, 166 Main
 1940 Rosahn, Paul Dolin, New Britain Hospital
 1930 Shechtman, Charles Theodore, 81 W. Main
 1931 Schupack, Samuel David, 99 W. Main
 1938 Scully, Roger Tehan, 55 West Main
 1930 Slys, Ladislaus Bernard, 589 Main
 1928 Smith, Vincent Joseph, 55 W. Main
 1936 Squillacote, Vincent Joseph, 33 S. High
 1938 Sullivan, Charles Noyes, 55 W. Main
 1940 Tisher, Paul Winslow, 99 West Main
 1935 Tokarczyk, John Joseph, 32 North
 1928 Waskowitz, David, 81 W. Main
 1934 Watson, William James, 272 Main
 1932 White, John Cowles, 55 W. Main

NEWINGTON

- 1934 Sills, Theodore Hopkins, 866 Main

PLAINVILLE

- 1878 Bull, John Norris, 57 Whiting
 1931 Cook, George Francis, 4 East Main
 1931 Frost, Lawrence Hubbard, 98 W. Main
 1934 Menousek, Joseph Albert, 14 E. Main
 1938 Tortolani, Aresto Peter, 75 E. Main

PLANTSVILLE

- 1937 Connor, George Michael, 772 S. Main

ROCKY HILL

- 1940 Kelley, Newell Raymond, 25 Riverview Rd.
 1904 Moser, Oran Alexander, Elm

SIMSBURY

- 1925 Murphy, Owen Lee, Weatogue
 1932 Stretch, James Edison, Hopmeadow

SOUTHINGTON

- 1935 Dudac, Thomas William, 9 Center
 1933 Gura, George Michael, 22 Main
 1935 Nagle, William Thomas, 23 Woodruff
 1929 Simmons, Eric Melville, 93 Main
 1929 Thalberg, Reuben Edward, 32 N. Main

SUFFIELD

- 1938 Coates, Stephen Paul, 328 Main
 1929 Levy, William, 339 Main
 1930 Upton, William Hart, 394 Main

UNIONVILLE

- 1937 Dunne, Edward Patrick, Main
 1941 O'Connell, Enos Joseph, 60 Main

WEST HARTFORD

- 1931 Case, Edward Percy, 28 Brunswick Ave.
 1905 Clifton, Harry Colman, P. O. Box 18
 1932 Crawley, George Andrew, 330 Park Rd.
 1928 Cushman, Laurence Arnold, 23 S. Main
 1922 Davis, James Edward, 1961 Boulevard
 1910 Denne, Thomas Harmon, 39 N. Main
 1926 Glazier, J. Raymond, 26 Sequin Rd.
 1939 Gray, Albert Stanley, 1271 Farmington Ave.
 1930 Griggs, John Bolter, 38 Orchard Rd.
 1913 Harrington, Amos Thomson, 31 Foxcroft Rd.
 1939 Hollinshead, Joseph Bentley, 1018 Farmington Ave.
 1932 Lundborg, Francis Ludwig, 31 N. Main
 1935 MacLean, Ethel Margaret, 32 Bishop Rd.
 1935 Martin, John Garthwaite, 7 S. Main
 1939 Murphy, Thomas Denis, 957 Farmington Ave.
 1930 Parshley, Philip Ford, 20 S. Quaker Lane
 1937 Rogers, Frederick Peckham, 783 Farmington Ave.
 1924 Root, Maurice Timothy, 51 N. Main
 1935 Root, Sophie Andrews, 51 N. Main
 1910 Rowley, John Carter, 17 Colony Rd.
 1901 Smith, Earl Terry, Sunset Farm
 1935 Standish, Hilda Crosby, Greenridge Lane, Sunset Farm
 1936 Stewart, Lester Quentin, 69 S. Main
 1937 Tait, Arthur Alfred, 333 Park Rd.
 1934 Winters, John Thomas, 3 S. Main

ELMWOOD

- 1941 Sewall, Sydney, 1700 New Britain Ave.

WETHERSFIELD

- 1938 Carvey, Edward Vincent, 28 Marsh
 1933 Howard, Harold Amasa, 330 Main
 1924 Ingraham, A. Elizabeth, 302 Wolcott Hill Rd.
 1938 Lewis, Henry Ryle, 382 Ridge Rd.
 1927 Smith, William Bowers, 91 Center
 1935 Stempa, Henry, 504 Wolcott Hill Rd.
 1932 Storms, William Frederick, 147 Main
 1940 Warren, Henry Stanley, 184 Main

WINDSOR

- 1930 MacCready, William Harold, 38 Elm
 1939 Monacella, John Manilla, 18 Elm
 1924 Pratt, Aaron Paul, 253 Broad

WINDSOR LOCKS

- 1921 Coyle, Anna Elizabeth Mulheron, 16 Church
 1937 Coyle, Bruce James, 2 Chestnut

OUT OF COUNTY

- 1911 Cobb, Albert Edward, Canaan
 1900 Enders, Thomas Burnham, Mystic
 1932 Filson, Ralph Marshall, 107 Tullamore Rd., Garden City, L. I., N. Y.
 1940 Garofalo, Mario Louis, 855 Orange, New Haven
 1934 Horning, Benjamin Graham, 1790 Broadway, N. Y. C.
 1928 Mahoney, Daniel F. C., P. O. Box 908, Palm Springs, Calif.
 1940 Osborne, Raymond Lester, Bellevue Hospital, N. Y. C.
 1902 Purinton, Charles Oscar, U. S. Veterans Hospital, Sunmount, N. Y.
 1940 Silver, Gershon Benjamin, Fort Wright, L. I., N. Y.
 1923 Walker, William Hastings, Newtown
 1938 Whitcomb, Benjamin Bradford, New Haven Hospital, New Haven

LITCHFIELD COUNTY ASSOCIATION

President: HERBERT C. OELSCHLEGEI, 19 Maiden Lane, Torrington

Vice-President: ROBERT C. SELLEW, SR., West Main St., No. Canaan

Secretary-Treasurer: W. BRADFORD WALKER, Cornwall

Councilor: CHARLES A. TURKINGTON, On-the-Green, Litchfield

Annual Meeting, Fourth Tuesday in April

Semi-Annual Meeting, First Tuesday in October

CORNWALL

- 1940 Walker, Robert
 1922 Walker, Wilmarth Bradford

CORNWALL BRIDGE

- 1938 Clarke, William Cogswell
 1931 Evarts, Josephine, Warren Rd.

KENT

- 1938 Bruyere, Paul Tulane, Kent School

LITCHFIELD

- 1921 Childs, Albert Ewing, West
 1935 Kilgus, John Frank, Jr., 80 West
 1910 Turkington, Charles Henry, On-the-Green
 1896 Warner, Charles Norton, North
 1939 Warner, Charles Norton, Jr., North
 1936 Wray, Edward Halloway, Jr., Torrington Rd.

NEW HARTFORD

- 1937 Ashley, Homer Champion, Main

NEW MILFORD

- 1938 Day, Rupert F.
 1938 Ignace, Stephen James, 40 Church
 1938 Stevens, Howard Granson

NORFOLK

- 1937 Barstow, Richard Iddings, The Village Green
 1909 Pinney, Almon William, Greenwoods Rd., E.
 1934 Ursone, Frank Domenico, Greenwoods Rd., W.

NORTH CANAAN

CANAAN

- 1929 Adam, Forbes Sampson
 1935 Elliott, John Richard
 1924 Sellew, Robert Cowan
 1938 Sellew, Richard Cowan, Jr.

PLYMOUTH

TERRYVILLE

- 1913 Lawton, Richard John, 9 N. Main
 1939 Wilcox, Lloyd Mather, 19 Maple

SALISBURY

LAKEVILLE

- 1933 Herrick, Francis Leach
 1923 Peterson, Clark Kimball
 1936 Wieler, Harry Julius, Horthkiss School

SHARON

- 1904 Chaffee, Jerome Stuart, Sharon Hospital
 1931 Hansell, Howard Russell, W. Main

THOMASTON

- 1938 Atha, Henry George, 44 Union
 1928 Curran, Harold Joseph, Main
 1903 Hazen, Robert, 45 Union
 1910 Kane, James Hugh, 205 S. Main
 1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

- 1898 Barker, Abram James, 216 Main
 1937 Bienkowski, Joseph George, 40 Main
 1898 Carlin, Charles Henry, 236 Main
 1930 Danaher, Thomas Joseph, 106 Litchfield
 1935 Garston, Louis Edward, 49 Main
 1931 Giobbe, Michael Edward, 24 E. Main
 1936 Goldberg, Isadore Solomon, 5 Water
 1908 Hanchett, Harry Bigelow, 51 Main
 1936 Hill, Emerson Stanley, 51 Main
 1941 Hubert, Gilbert Richard, 24 Church
 1917 Kennedy, William Clement, 106 Main
 1938 Kott, Joseph Henry, 18 Pearl
 1936 LoRusso, Domenico Leonardo, 40 Main
 1938 Murcko, William John, 497 Main
 1923 Oelschlegel, Herbert Charles, 19 Maiden Lane
 1938 Orlovski, Andrew William, 40 Main
 1923 Polito, Frank Leonard, 16 Litchfield
 1887 Pratt, Elias, 27 Daycoeton Pl.
 1936 Sutherland, Francis Alexander, 24 Mason
 1917 Thomson, Thomas Leonard, 24 Mason
 1898 Wadhams, Sanford Hosea, 908 Main
 1917 Weed, Floyd Albert, 199 Main

WASHINGTON

- 1927 Jackson, Arthur Hartt
 1908 Wersebe, Frederic William

WATERTOWN

- 1936 Cleary, Harold John, Main
 1897 Loveland, Ernest Kilborn, 48 North
 1922 Martin, James Smith
 1936 Meyers, Royal Abbott, 162 Main
 1919 Reade, Edwin Godwin, 429 Main
 1937 Reichenbach, Frank, 429 Main

WINCHESTER

WINSTED

- 1938 Baker, Philip George, 442 Main
 1936 Cornelio, Francis Joseph, 153 Main
 1933 Derwin, James Joseph, 350 Main
 1915 English, Chester Ferrin, 64 Main
 1937 Gallo, Francis, 384 Main
 1927 Herman, Donald Warner, 486 Main
 1936 Levy, Aaron, 384 Main
 1912 Reidy, Maurice Joseph, 350 Main
 1922 Sanderson, Roy Voter, 570 Main

WOODBURY

- 1913 Allen, Howard Sanford

NORTH WOODBURY

- 1940 Markle, Raymond Dunsmore, Pleasant

OUT OF COUNTY

- 1939 La Taif, C. George, 96 Park Ave., Danbury
 1881 Platt, William Logan, State Hospital, P. O. Box 476,
 Norwich
 1914 Woodward, Harold Burton, 321 Main, Bristol

MIDDLESEX COUNTY ASSOCIATION

President: HARRY S. FRANK, 144 Washington St., Middletown
Vice-President: EDGAR FAUVER, 55 Vernon St., Middletown
Secretary: CHARLES RUSSMAN, Box 361, Middletown
Councilor: ALFRED SWEET, 50 Crescent St., Middletown

Annual Meeting, Second Thursday in April

Semi-Annual Meeting, Second Thursday in October

CHESTER

- 1941 Callender, Eugene Frederick, Drawer F
 1935 Lieberman, David Leonard

CLINTON

- 1937 Rindge, Norman Pember, 49 Pearl
 1935 Stone, Harry Russell, 67 West Main

CROMWELL

- 1934 Couch, Frank Hallock, Cromwell Hall
 1934 Couch, Mildred Warden, Cromwell Hall
 1940 Grant, Richard Francis, 221 Main
 1928 Nelson, Walter Nathaniel, 76 Main
 1925 Pierson, Emily Miller, 107 Main

DURHAM

- 1940 Sherwood, Henry, Main

EAST HADDAM

- 1924 Crook, Joseph Bruce, P. O. Box No. 133

EAST HAMPTON

- 1936 Gardner, Norman Homer
 1934 Soreff, Louis, 15 Main

ESSEX

- 1903 Bradeen, Frederick Barton, P. O. Box No. 221
 1908 Davis, Charles Clarence, 5 S. Main
 1938 Scott, James Clifford, 20 West Ave.

HIGGANUM

- 1905 Burr, Noah Arthur

MOODUS

- 1935 Horsefield, Thomas Earl, P. O. Box 40

MIDDLETOWN

- 1933 Beauchemin, Joseph Adelard, Connecticut State Hos-
 pital
 1941 Buckley, Willard Emrich, Middlesex Hospital
 1937 Calhoun, Hazen Albert, Jr., 647 Main
 1926 Chase, Carl Clarence, 121 Main
 1928 Compson, Florence Eberly Mentzer, Connecticut State
 Hospital
 1924 Craig, George Mansfield, 119 Main
 1912 Fauver, Edgar, 327 High
 1933 Fekety, Stephen Henry, 675 Main
 1921 Felt, Paul Revere, Connecticut State Hospital
 1900 Fisher, Jessie Weston, 28 Crescent
 1927 Frank, Harry Selig, 144 Washington
 1937 Geck, Otto Francis, Box 361
 1931 Gissler, Norman Edwin, 164 Court
 1927 Grower, Julius Harry, 164 Court
 1920 Harvey, Carl Clifford, 119 Main
 1924 Holley, Erving, Connecticut State Hospital
 1924 Joyce, William Michael, 121 Main
 1928 LaBella, Louis Oronato, P. O. Box 417
 1920 Leak, Roy Lathen, Connecticut State Hospital
 1925 Loffredo, Louis, 77 Crescent
 1929 Magnano, Joseph, 100 Broad
 1940 McLeod, Christie Ellen, 28 Crescent
 1934 Minor, Lloyd Wesley, 119 Main
 1941 Mozzer, Alexander John, Connecticut State Hospital
 1896 Murphy, James, 101 Broad
 1939 Palmieri, Mario Lorenzo, 43 S. Main
 1928 Piasta, Peter Ferdinand, 602 Main
 1889 Potter, Frank Edward, 160 College
 1940 Powers, John T. H., 363 Main
 1930 Ricksher, Charles, 97 Broad
 1934 Roccapriore, Benjamin Anthony, 504 Main
 1926 Russmann, Charles, Connecticut State Hospital
 1929 Speight, Harold Edmund, 642 Main
 1924 Sweet, Alfred Norton, 70 Crescent
 1933 Tracy, Frederick Erwin, 120 Pearl
 1919 Van Cor, Chester Arthur, Connecticut State Hospital
 1933 Whiting, Harry St. John, Connecticut State Hospital
 1925 Wilder, Ella Annis, 80 S. Main
 1922 Wrang, William Emil, 294 Main

OLD SAYBROOK

- 1941 Deming, Nelson Lloyd
 1905 Granniss, Irwin, P. O. Box 312
 1934 Greenberg, Aaron, Main

PORTLAND

- 1938 Prout, Edgar Bacon, 48 Bartlett
 1933 Schwartz, Philip Edward, 309 Main

- 1932 Wagner, Carl Phillips, 25 Marlborough
1934 Waterman, Chester, Bartlett

SAYBROOK

DEEP RIVER

- 1939 Lobb, Russell Albert, 131 Main
1903 Pratt, Arthur Milton, P. O. Box 477
1932 Tate, William James, Elm

OUT OF COUNTY

- 1935 Elliott, George Albert, Brattleboro Retreat, Brattleboro, Vermont
1904 Kingman, James Henry, 96 Everit, New Haven

NEW HAVEN COUNTY ASSOCIATION

President: FREDERICK N. SPERRY, 107 Whitney Ave., New Haven

Vice-President: WILLIAM J. H. FISCHER, 3 Lafayette St., Milford

Secretary: RALPH E. McDONNELL, 158 Whitney Ave., New Haven

Councilor: THOMAS P. MURDOCK, 147 W. Main St., Meriden
Annual Meeting, Fourth Thursday in April
Semi-Annual Meeting, Fourth Thursday in October

ANSONIA

- 1916 Aaronson, Michael S., 410 Main
1937 Alu, Anthony F., 290 Main
1935 Blumenthal, Edward Jedediah, 88 Main
1938 Casagrande, John Joseph, 178 Main
1941 O'Neil, William Henry, 156 Main
1907 Parmelee, Edward Kibbe, 50 Main
1932 Renchan, John Michael, 100 Main
1924 Senfield, Maxon Major, 110 Main
1924 Steudel, Henry, 88 Main
1924 Thomas, John Joseph, 290 Main

BRANFORD

- 1934 Blanchard, Dana Lincoln, 87 Main
1931 Bodie, William Joseph, 146 Montowese
1940 Carpinella, Michael Joseph, 48 Kirkham
1917 Gaylord, Charles Woodward, 93 S. Main
1929 Levy, Nathan, 94 Main
1916 McQueen, Arthur Samauel, 187 Montowese

PINE ORCHARD

- 1919 Smith, George Milton

CHESHIRE

- 1911 Herr, Edward Albert, Main
1923 Moore, Wilbur John, Maple Ave.
1940 Neff, William Everett, Jr., Main
1939 Oxnard, Edward Warren, Maple Ave.

DERBY

- 1916 Baldwin, Charles Tomlinson, 74 Fourth
1927 Burns, George Dewey, 272 Main
1940 D'Ambruoso, Dominic Charles, 3 Elizabeth
1940 Dreher, Samuel Meyers, 282 Main
1910 Parlato, Michael Antonio, 270 Elizabeth
1890 Pinney, Royal Watson, 116 Derby Ave.
1914 Plunkett, Thomas Francis, 18 Elizabeth

- 1925 Rentsch, Samuel Burton, 61 Seymour Ave.
1940 Stygar, Joseph Stanislaus, 272 Main
1910 Treat, William Howard, 258 Main

EAST HAVEN

- 1940 Balletto, Vincent, 265 Main
1940 Grenon, Ovidia Arzidas, 586 Thompson Ave.
1924 Taylor, Robert Mitchell, 578 Thompson Ave.

GUILFORD

- 1941 McGuire, Frank James, 29 Whitfield
1916 Smith, Frederic DeWitt, 55 Park

HAMDEN

- 1937 Case-Downer, Muriel, 95 Wayland
1936 Corey, Walter Van Arsdale, 1188 Whitney Ave.
1926 Ematrudo, Frederick Roys, 1756 Whitney Ave.
1941 Grillo, Vincent James, 1324 Dixwell Ave.
1904 Lay, Walter Sidders, 2320 Whitney Ave.
1941 Riccio, Joseph Salvatore, 52 Putnam Ave.
1927 Slater, Morris, 1100 Dixwell Ave.

MADISON

- 1929 Hughson, Donald Thomas, Boston Post Rd.
1908 Rindge, Milo Pember, Boston Post Rd.

MERIDEN

- 1934 Affinito, Thomas, 128 W. Main
1929 Campbell, Sherbourne, 147 W. Main
1928 Caplan, Henry, 27½ W. Main
1939 Caplan, Max, 197 Cooke Ave.
1937 Carey, William Clark, 61 Colony
1924 Carroll, William Edward, Undercliff
1937 Cohen, David Jerome, 3 Colony
1926 Conroy, Michael Joseph, 64½ E. Main
1939 de La Vergne, Paul Mason, Undercliff
1927 DeRosa, Sylvester Frank, 90 W. Main
1930 Foster, Edward Wendell, 147 W. Main
1940 Fox, George Graham, 147 W. Main
1921 Gibson, Cole Blease, Undercliff
1929 Hall, William Edward, 147 W. Main
1941 Katz, Irving, 42½ E. Main
1939 L'Heureux, Jerome Arthur, 93 E. Main
1896 LaPointe, John William Henry, 56½ W. Main
1939 Liebow, Averill Abraham, 12 King
1907 Lockwood, Howard DeForest, 248 E. Main
1938 McCullough, Edward Alloysius, 53½ W. Main
1934 Mekrut, Joseph Anthony, 34½ W. Main
1928 Mills, Bernard Litchfield, 94 E. Main
1934 Misuk, Joseph Francis, 489 Broad
1913 Murdock, Thomas Patrick, 147 W. Main
1921 Otis, Fessenden Newport, 165 W. Main
1920 Otis, Israel Sabine, 165 W. Main
1932 Pennington, Harry Freeman, 455 Broad
1937 Petrucelli, Rocco Joseph, 147 W. Main
1931 Pierson, Louis A., 199 W. Main
1916 Quinlan, Raymond Vincent, 5 State
1913 Smith, David Parker, 199 W. Main
1935 Solomon, Charles Isadore, State School for Boys
1940 Stoddard, John Elias, 119 W. Main
1934 Strickland, Harold, 128 W. Main
1921 Tower, Arthur Augustus, 147 W. Main
1936 Van Antwerp, Lee Douglas, Undercliff

- 1940 Van Leuvan, James Sipple, 61 Colony
 1921 Wilson, James Alfred, 61 Colony

MILFORD

- 1938 Barney, Walter Edward, 186 Broad
 1932 Budau, John Harry Diederichs, 741 E. Broadway
 1913 Fischer, William John Henry, 3 Lafayette
 1929 Geib, Henry Albert, Zion Hill Rd.
 1932 Heady, Carlton Kellogg, 26 Cherry
 1928 Hyde, Clinton John, 157 Gulf
 1939 Lee, Frank Nelson, 56 Broad
 1941 Stetson, Charles Greaves, 114 Broad
 1933 Stetson, Harry Warren, 114 Broad
 1940 Viola, Carl Philip, 2½ Broad

DEVON

- 1934 Andrus, Oliver Burton, 531 Daytona Ave.
 1941 Lee, John Ranks, 522 Colonial

NAUGATUCK

- 1922 Duffy, Vincent Paul, 83 Meadow
 1923 Hill, William Edward, 150 Meadow
 1940 Kennedy, Charles Stephen, 175 Meadow
 1938 Reilly, Walter John, 170 Meadow
 1937 Towne, Nehemiah Alvarado, 19 Hillside Ave.
 1926 Williams, Edward Everett, 269 Church

UNION CITY

- 1940 Tylec, Leo Louis, 359 N. Main

NEW HAVEN

- 1935 Abbey, Edward Augustin, 255 Bradley
 1937 Abrashkin, Mortimer Dick, 1187 Chapel
 1941 Aiello, Louis James, 37 Maple
 1921 Alderman, Irving Saunders, 204 Park
 1925 Allen, Edward Pratt, 27 Elm
 1902 Allen, Millard Filmore, 65 Dixwell Ave.
 1893 Alling, Arthur Nathaniel, 257 Church
 1919 Alpert, Reuben Harry, 1142 Chapel
 1932 Amatruda, Frank Gabriel, 542 Chapel
 1908 Arnold, Harold Sears, 442 Temple
 1930 Arnold, Hermann Bruno, 49 Dwight
 1916 Baldwin, William Pitt, 1226 Chapel
 1940 Barald, Fred Charles, 487 Dixwell Ave.
 1920 Barker, Creighton, 258 Church
 1900 Barnes, William Samuel, 265 Church
 1908 Barrett, William Joseph, 546 Chapel
 1896 Bartlett, Charles Joseph, 183 Bishop
 1936 Bassin, Alexander Lewis, 789 Howard Ave.
 1930 Batelli, Clement Francis, 161 Church
 1925 Battista, Anthony William, 111 Osborn Ave.
 1934 Bayne-Jones, Stanhope, 310 Cedar
 1909 Beck, Frederick George, 193 York
 1926 Behan, Edmund Joseph, 1370 Chapel
 1931 Benedict, Mary Kendrick, 85 Whitney Ave.
 1911 Bergman, Axel P., 27 Elm
 1940 Berlowe, Max Llewellyn, 60 Trumbull
 1920 Berman, Harry Loring, 1142 Chapel
 1940 Biondi, Benedict, 1593 Chapel
 1939 Bishop, Courtney Craig, 158 Whitney Ave.
 1907 Blake, Eugene Maurice, 303 Whitney Ave.
 1922 Blake, Francis Gilman, 789 Howard Ave.
 1927 Blodinger, Israel Edward, 1142 Chapel

- 1907 Blumer, George, 158 Whitney Ave.
 1911 Boardman, Albertus Kellogg, 441 Forbes Ave.
 1922 Boardman, Emma Irene, 161 Church
 1926 Bodie, John Allen, 221 Columbus Ave.
 1939 Boisvert, Paul Leo, 1609 Chapel
 1919 Bonoff, Zelly Adam, 1204 Chapel
 1919 Bretzfelder, Karl Benjamin, 315 Whitney Ave.
 1935 Brody, Bernard Stephen, 303 Whitney Ave.
 1940 Brown, Warren Thompson, 333 Cedar
 1938 Bruckner, William J., 129 Whitney Ave.
 1930 Bumstead, John Henry, 256 Bradley
 1934 Canfield, Norton, 789 Howard Ave.
 1928 Capecelatro, Alfonso, 142 Columbus Ave.
 1916 Carelli, Genesis Frank, 27 Elm
 1932 Celentano, Luca Eugene Humbert, 115 Howe
 1892 Cheney, Benjamin Austin, 265 Church
 1934 Claiborn, Louie Nixon, 303 Whitney Ave.
 1937 Clark, Mildred Helen, 244 Sherman Ave.
 1938 Clarke, Clement Cobb, 158 Whitney Ave.
 1935 Climo, Samuel, 1172 Chapel
 1923 Cobey, James Francis, 1210 Chapel
 1922 Coffey, James Ryle, 216 Grand Ave.
 1925 Cofrances, Louis William, 190 Winthrop Ave.
 1901 Cohane, Jeremiah Joseph, 59 College
 1904 Cohane, Timothy Francis, 400 Congress Ave.
 1924 Cohen, William, 1195 Chapel
 1917 Collins, William Francis, 66 Trumbull
 1921 Colwell, Howard Spencer, 129 Whitney Ave.
 1914 Comfort, Charles Williams, Jr., 27 Elm
 1931 Connolly, Arthur James, 59 Trumbull
 1914 Conte, Harry Albert, 5 Elm
 1939 Conte, Mario Gero, 334 Grand Ave.
 1921 Cook, Robert Jay, 85 Whitney Ave.
 1931 Corradino, Charles Louis, 516 Howard Ave.
 1921 Creadick, Abraham Nowell, 79 Trumbull
 1936 Culotta, Charles Salvatore, 388 Orange
 1940 Cutler, Herman Shepard, 425 Forbes Ave.
 1924 Dallas, Marion, 248 Bradley
 1935 D'Amico, Michael, 303 Whitney Ave.
 1934 Darrow, Daniel Cady, 789 Howard Ave.
 1939 Davis, Jachin Boaz, 158 Whitney Ave.
 1920 Dayton, Arthur Bliss, 129 Whitney Ave.
 1920 Denning, Charles Kenneth, 257 Church
 1922 Denning, Clyde Leroy, 789 Howard Ave.
 1925 Dennehy, William James, 1282 State
 1935 D'Esopo, Joseph Nicholas, 789 Howard Ave.
 1908 Diefendorf, Allen Ross, 121 Whitney Ave.
 1940 DiStasio, Frank, 434 Temple
 1938 Dobbs, William G. H., 1418 Chapel
 1922 Duffy, William Core, 608 Whitney Ave.
 1923 Errico, Louis, 26 Elm
 1925 Evans, Theodore Schlosser, 59 Trumbull
 1935 Fenney, Philip William, 705 Dixwell Ave.
 1913 Ferguson, Robert John, 59 College
 1929 Fiskio, Peter William, 307 Humphrey
 1914 Flynn, Charles Thomas, 41 Trumbull
 1917 Flynn, David Aloysius, 326 Grand Ave.
 1929 Flynn, Harold Aloysius, 464 Dixwell Ave.
 1940 Foley, Francis Edward, 588 Ferry
 1888 Foote, Charles Jenkins, 257 Church
 1929 Foster, Lewis Chandler, 256 Bradley
 1925 Fox, James Charles, Jr., 789 Howard Ave.

- 1924 Freedman, Barnett Philip, 322 George
 1936 Freeman, David, 60 Trumbull
 1940 Friedman, Irving, 315 Whitney Ave.
 1937 Fry, Clements Collard, 109 College
 1938 Geiger, Arthur Joseph, 789 Howard Ave.
 1939 Gendel, Benjamin Robert, 113 Sherman Ave.
 1937 Gentile, Angelo Louis, 601 Chapel
 1920 Geraei, Lucian Arthur, 546 Chapel
 1937 German, William John, 789 Howard Ave.
 1941 Gerstl, Bruno, 421 George
 1923 Gettings, James Augustus, 209 Whalley Ave.
 1924 Giamarino, Henry James, 532 Chapel
 1923 Giannotti, Carl Charles, 214 Lafayette
 1940 Gildea, Edwin Francis, 333 Cedar
 1941 Gildea, Margaret C. L., 158 Whitney Ave.
 1926 Glazer, Morris, 1204 Chapel
 1941 Godfried, Milton Simons, 59 College
 1910 Goldberg, Samuel James, 43 Trumbull
 1941 Goldberg, Samuel James, Jr., 43 Trumbull
 1912 Goldman, George, 201 Park
 1927 Goldstein, Morris, 451 George
 1935 Goldstein, Richard Moses, 333 Cedar
 1941 Granoff, Morris Aaron, 255 Bradley
 1924 Greenhouse, Barnett, 107 Whitney Ave.
 1927 Groak, Joseph Anthony, 145 Grand Ave.
 1931 Grodin, Herman Wolmer, 840 Howard Ave.
 1939 Guida, Francis Paul, 107 Whitney Ave.
 1936 Hankin, Morris Albert, 43 Trumbull
 1930 Harris, Benedict Richard, 176 Dwight
 1937 Harris, Jesse Samuel, 176 Dwight
 1931 Harrison, Elizabeth Ross, 255 Bradley
 1935 Hart, James Clement, 820 Elm
 1920 Harvey, Samuel Clark, 789 Howard Ave.
 1937 Hathaway, John Seabury, 109 College
 1941 Heinemann, Martii, 81 Ellsworth Ave.
 1916 Hendricks, Albert Ludwig, 26 Trumbull
 1907 Henze, Carl William, 466 Orange
 1925 Herrmann, Julian Bertram, 204 Park
 1937 Hess, Orvan Walter, 79 Trumbull
 1930 Higgins, Joseph John, 48 Dwight
 1922 Hillman, Maurice Manuel, 1249 Chapel
 1927 Hippolitus, Jean DeFrancis, 1447 Chapel
 1916 Hirata, Isao, 1455 Chapel
 1940 Hirshfeld, John Winslow, 789 Howard Ave.
 1924 Howard, Albert Joseph, 432 Whitney Ave.
 1935 Howard, Marion Edith, 789 Howard Ave.
 1915 Hynes, Frederick Henry, 195 Church
 1914 Jack, Gabriel Joseph, 347 Orange
 1924 Jack, John Louis, 412 Orange
 1936 Jackson, Edith Banfield, 333 Cedar
 1927 Jenkins, Ralph Hathaway, 59 College
 1933 Johnson, Carl Edward, 158 Whitney Ave.
 1919 Johnson, Edgar Mayer, 73 Howe
 1938 Jordan, Robert Hough, 59 Trumbull
 1937 Kahn, Eugen, 333 Cedar
 1938 Kennard, Margaret A., 333 Cedar
 1901 Kilbourn, Clarence Leishman, 202 Blatchley Ave.
 1938 Klatskin, Gerald, 2 Lincoln
 1928 Klebanoff, Harry Erwin, 1497 Chapel
 1917 Kleiner, Simon Bretzfelder, 315 Whitney Ave.
 1938 Klinghoffer, Kalmen Anselm, 789 Howard Ave.
 1940 Koufman, William Bernard, 45 Trumbull
 1935 Krosnick, Morris Yale, 1195 Chapel
 1935 Kuh, Clifford, 31 Howe
 1937 Kushlan, Samuel Daniel, 303 Whitney Ave.
 1940 Latimer, Marvin Luther, 129 Whitney Ave.
 1936 Lavietes, Paul Harold, 789 Howard Ave.
 1915 Lear, Maxwell, 1172 Chapel
 1935 Leddy, Percy Allen, 109 College
 1939 Lehman, Edward Burton, 1142 Chapel
 1938 Leonard, John Charles, 789 Howard Ave.
 1923 Levin, Hyman Alexander, 1142 Chapel
 1920 Levy, Daniel Frederick, 5 College
 1905 Lewis, Dwight Milton, 169 Church
 1923 Lewis, Robert Morton, 52 Trumbull
 1911 Linde, Joseph Irving, City Hall
 1934 Linskog, Gustaf Elmer, 789 Howard Ave.
 1919 Little, Herman Clark, 303 Whitney Ave.
 1927 Logan, William Joseph, 412 Whalley Ave.
 1926 MacCready, Paul Beattie, 442 Temple
 1878 Mailhouse, Max, 195 Church
 1927 Marshall, Carter Lee, 198 Dixwell Ave.
 1928 Marvin, Harold Myers, 303 Whitney Ave.
 1921 Massa, Anthony Francis, 697 Elm
 1931 Mastroianni, Luigi, 248 Bradley
 1925 Maurer, Lloyd Leslie, 41 Trumbull
 1920 Maynard, Harry Hilts, 882 Howard Ave.
 1934 McAlleney, Paul Francis, Jr., 79 Trumbull
 1922 McDonnell, Ralph Edward, 158 Whitney Ave.
 1913 McGuire, William Charles, 104 Park
 1899 McIntosh, Edward Francis, 307 Alden Ave.
 1940 Mendelsohn, William, 442 Temple
 1916 Mendillo, Anthony Joseph, 45 Trumbull
 1933 Mendillo, John Carleton Francis, 255 Bradley
 1938 Mignone, Joseph, 388 Orange
 1941 Miller, Herbert Chauncey, Jr., 789 Howard Ave.
 1930 Mongillo, Frank, 5 Elm
 1916 Morse, Arthur Henry, 789 Howard Ave.
 1922 Musselman, Luther Kyner, 215 Whitney Ave.
 1921 Nahum, Louis Herman, 1142 Chapel
 1940 Nesbit, Robert Raymond, St. Raphael's Hospital
 1922 Newman, Joseph Thomas, 150 Shelton Ave.
 1914 Nichols, Ralph Wilbur, 57 Trumbull
 1932 Nodelman, Jacob, 5 Elm
 1933 O'Brasky, Louis, 1172 Chapel
 1920 O'Brien, William Henry Joseph, 265 Church
 1922 O'Connor, Denis Stanislaus, 158 Whitney Ave.
 1931 Oughterson, Ashley Webster, 789 Howard Ave.
 1936 Palmieri, Michael Walter, 551 Howard Ave.
 1938 Parente, Leonard, 64 Trumbull
 1929 Paul, John Rodman, 789 Howard Ave.
 1894 Peek, Robert Ellsworth, 1418 Chapel
 1940 Perham, William Sidney, 58 Trumbull
 1922 Perrins, Harlan Bassett, 59 Trumbull
 1925 Peters, John Punnett, 789 Howard Ave.
 1927 Petrelli, Joseph, 455 Orange
 1923 Philipson, Samuel, 61 Park
 1909 Phillips, Frank Lyman, 405 Temple
 1935 Piazza, George Joseph, 78 Orchard
 1931 Pinn, Abraham Samuel, 75 Sherman Ave.
 1927 Poole, Allan King, 107 Whitney Ave.
 1938 Poverman, David, 67 Trumbull
 1927 Powell, Wilson, 1266 Forest Rd.
 1925 Powers, Grover Francis, 789 Howard Ave.

1934 Rademacher, Everett Stanley, 442 Temple
 1903 Rand, Richard Foster, 246 Church
 1903 Reilly, Francis Henry, 230 Church
 1924 Riccitelli, Mariano Louis, 476 Howard Ave.
 1937 Robbins, Clarence Loveridge, 158 Whitney Ave.
 1929 Roberts, Frederick William, 129 Whitney Ave.
 1920 Rogers, Orville Forrest, 109 College
 1929 Rogowski, Bernhard Albert, 75 Whitney Ave.
 1932 Rothschild, Morris Loeb, 265 Church
 1941 Rozen, Alan Abraham, 224 Norton
 1937 Rubin, George Alan, 1150 Chapel
 1914 Russell, Thomas Hubbard, 57 Trumbull
 1922 Russell, Walter Irving, 317 Whalley Ave.
 1920 Russo, Joseph Daniel, 120 Blatchley Ave.
 1921 Ryder, William Harold, 185 Church
 1940 Sadusk, Joseph Francis, Jr., 789 Howard Ave.
 1933 Salinger, Robert, 256 Bradley
 1910 Sanford, Charles Edwin, 265 Church
 1939 Savarese, Melchior F. R., 41 Howe
 1911 Scarbrough, Marvin McRae, 47 Trumbull
 1931 Scholl, Robert Frederick, 215 Whitney Ave.
 1924 Scott, Clifton Russell, 215 Whitney Ave.
 1920 Seabury, Robert Brewster, 64 Trumbull
 1916 Segnalla, Ernest, 613 Chapel
 1923 Serafin, Peter James, 809 State
 1937 Shaffer, Thomas Eugene, 107 Whitney Ave.
 1928 Shay, Francis Leo, 368 Alden Ave.
 1923 Shea, Michael Stephen, 500 Howard Ave.
 1915 Sheahan, William Lawrence, 59 College
 1929 Shure, Abraham Lewis, 85 Whitney Ave.
 1940 Sigel, Harry, 1172 Chapel
 1923 Silverberg, Samuel Joshua, 201 Park
 1913 Skiff, Stuart Ernest, 1194 Chapel
 1923 Smith, Charles Seaver, 59 College
 1914 Smith, Marvin, 356 Humphrey
 1927 Snurkowski, Charles Vincent, 487 Orange
 1927 Sperandeo, Anthony, 538 Chapel
 1896 Sperry, Frederick Noyes, 107 Whitney Ave.
 1939 Spinner, Samuel, 45 Trumbull
 1907 Standish, Frank Billings, 193 York
 1936 Stevens, Marvin Allen, 256 Bradley
 1916 Stewart, Harry Eaton, 262 Bradley
 1925 Stone, Emerson Law, 129 Whitney Ave.
 1920 Strauss, Maurice Jacob, 41 Trumbull
 1897 Sullivan, John Francis, 1346 Chapel
 1923 Sullivan, Thomas Joseph, 495 Orange
 1941 Sword, Brian Collins, 116 Everit
 1939 Tennant, Robert, 310 Cedar
 1938 Thompson, Kenneth Wade, 789 Howard Ave.
 1936 Thompson, Lloyd James, 333 Cedar
 1915 Thoms, Herbert, 789 Howard Ave.
 1940 Thorne, Lewis, 109 College
 1911 Tileston, Wilder, 442 Temple
 1922 Toole, Frank Edward, 419 Whalley Ave.
 1911 Tracy, Robert Graham, 493 Howard Ave.
 1925 Trask, James Dowling, 789 Howard Ave.
 1923 Tyler, Margaret, 158 Whitney Ave.
 1896 Verdi, William Francis, 27 Elm
 1924 Vestal, Paul William, 79 Trumbull
 1926 Wakeman, Edward Taylor, 129 Whitney Ave.
 1919 Weil, Arthur, 85 Whitney Ave.
 1902 Welch, Harry Little, 59 College

1907 Wheatley, Louis Frederick, 61 Trumbull
 1916 Whiting, Leonard Clark, 121 Whitney Ave.
 1906 Whittemore, Edward Reed, 33 Whitney Ave.
 1936 Wies, Frederick Albert, 255 Bradley
 1941 Wilkinson, Arthur Gilbert, 59 Trumbull
 1931 Willner, Otto, 61 Trumbull
 1941 Wilson, Dwight Elliott, 70 Howe
 1935 Wilson, Hugh Monroe, 789 Howard Ave.
 1931 Wilson, William Rives, 58 Trumbull
 1939 Winkler, Alexander Woodward, 789 Howard Ave.
 1899 Winne, William Nelson, 1020 Whalley Ave.
 1921 Winternitz, Milton Charles, 310 Cedar
 1922 Winters, Sidney, 1175 Chapel
 1941 Woodbridge, Philip Dudley, 1418 Chapel
 1895 Wurtenberg, William Charles, 445 St. Ronan
 1924 Yavis, John Constantine, 115 Dwight
 1920 Yudkin, Arthur Meyer, 257 Church
 1933 Zimmerman, Harry Martin, 310 Cedar

NORTH HAVEN

1941 Cashman, Justin Laurence, Broadway
 1913 Lang, William Peter, The Cedars
 1940 Parrella, Louis Arnold, Broadway
 1923 Taylor, Sterling Price, Broadway and Post Rd.

SEYMOUR

1938 Chobian, Joseph Aloysius, 159 Main
 1941 Harvey, Edward Regis, 119 Main
 1934 Rogol, Oscar, 135 Main

SOUTHBURY

1935 Yannet, Herman, Southbury Training School

WALLINGFORD

1932 Breck, Charles Arthur, 176 N. Main
 1908 Buffum, John Harold, 145 N. Main
 1930 Carrozella John Christy, 50 S. Main
 1941 Dayton, Theodore Read, Gaylord Farm
 1905 Lyman, David Russell, Gaylord Farm Sanatorium
 1911 McGaughey, James David, 261 Center
 1916 Morris, William Haviland, Gaylord Farm Sanatorium
 1940 Pelz, Siegmund, 5 North Main
 1925 Riordan, William James, 261 Center
 1919 Sheehan, Mark Thomas, 1 Williams
 1931 Spignesi, John Theodore, 37 N. Main
 1933 Wilson, George Campbell, Gaylord Farm Sanatorium

WATERBURY

1924 Allen, Harry Everett, 30 Prospect
 1929 Atkins, Samuel Maurice, 63 Central Ave.
 1923 Audet, Charles Henry, 95 N. Main
 1910 Barber, Walter Lewis, Jr., 87 N. Main
 1937 Berman, Bernard Alfred, 161 N. Main
 1908 Bevans, Theodore Frank, 111 W. Main
 1931 Bizzozero, Orpheus Joseph, 20 Grove
 1939 Bonner, Robert Alexander, 51 W. Main
 1910 Brennan, Patrick Joseph, 135 W. Main
 1928 Brown, Abe Solomon, 58 Central Ave.
 1894 Brown, Charles Henry, 57 N. Main
 1940 Burke, Joseph Francis, 135 W. Main
 1935 Collins, Joseph Osborn, Waterbury Hospital
 1932 Corbett, Herbert John, 14 Central Ave.
 1928 Cottiero, Thomas, 21 Cooke

1940 Damiani, Rudolph Andrea, 5 Cooke
 1907 Deming, Dudley Brainard, 67 Willow
 1912 Dillon, John Henry, 325 E. Main
 1927 Dreher, Alfred Charles, 171 N. Main
 1941 DuBois, Robert Lionel, 135 W. Main
 1902 Dwyer, Patrick James, 95 N. Main
 1917 Dye, John Sinclair, 111 W. Main
 1927 Edlin, Charles, 24 Central Ave.
 1916 Egan, John Joseph, 83 Willow
 1905 Engelke, Charles, 24 Central Ave.
 1922 Fabreant, Samuel Elmer, 9 Cooke
 1937 Finkelstein, William, 103 N. Main
 1926 Finn, Alfred Joseph, 164 W. Main
 1926 Fitzpatrick, Edward Earl, 83 E. Main
 1927 Foster, John Hess, 77 N. Main
 1928 Freiheit, John Martin, 85 Grove
 1937 Fruin, John William, 76 Center
 1909 Gancher, Jacob, 275 N. Main
 1923 Godfrey, Edward John, 135 W. Main
 1914 Good, William Murray, 63 Center
 1894 Goodenough, Edward Winchester, City Hall
 1940 Goodrich, William Albert, 138 Grove
 1915 Green, Jacques Henry, 171 N. Main
 1933 Harvey, Joseph LeRoy, 222 Ledgeside Ave.
 1930 Herrmann, Albert Edward, 101 N. Main
 1931 Hetzel, Joseph Linn, 103 N. Main
 1939 Hinchey, Richard James, 31 Leavenworth
 1919 Jackson, Andrew Joseph, 20 E. Main
 1929 Jackson, Edward Joseph, 76 Center
 1939 Jennes, Sidney Weinberg, 18 Central Ave.
 1922 Johnson, Arthur August, 59 Central Ave.
 1915 Johnston, Ernest Hillock, 18 Saving
 1914 Kirschbaum, Edward Harry, 20 Grove
 1940 LaBrecque, Frederick Charles, 164 W. Main
 1922 Larkin, Charles Lewis, 101 N. Main
 1910 Lawlor, Michael Joseph, 158 N. Main
 1907 Leonard, George Arthur, 79 N. Main
 1941 Lewicki, Edward Stanley, 36 North Main
 1927 Lindsay, Merrill Kirk, 300 W. Main
 1924 Lombardi, Pasquale Frederick, 46 Prospect
 1939 Margolius, Norman Calvin, 125 Grove
 1930 Mason, Broadstreet Henry, Waterbury Hospital
 1941 Mayo, Elliott Russell, 85 Grove
 1916 McGrath, John Henry, 309 E. Main
 1906 McLarney, Thomas Joseph, 27 Cherry
 1925 Merriman, Merritt Heminway, 115 Prospect
 1897 Moriarity, James Ligouri, 52 Holmes Ave.
 1928 Morrill, Harold Frost, 300 W. Main
 1928 Mueller, Richard Albert, 287 N. Main
 1932 Mullen, John Joseph, 135 W. Main
 1940 Nelson, Roger Burdette, 24 Central Ave.
 1929 Neuswanger, Chris Harold, 89 N. Main
 1923 Platt, Irving Smith, 77 N. Main
 1901 Pomeroy, Nelson Asa, 96 Hillside Ave.
 1940 Post, Edward Andrew, 135 W. Main
 1931 Pyle, Edwin, 95 N. Main
 1916 Quinn, Raymond James, 730 Baldwin
 1939 Reynolds, Joseph Alban, 95 N. Main
 1920 Root, James Harold, 103 N. Main
 1925 Ruby, Max Harold, 47 Prospect
 1939 Ruby, Robert James, 47 Prospect
 1914 Ryder, Raymond Harrison, 52 Central Ave.

1931 Sanduli, Gaetano Renato, 64 Cooke
 1928 Santoro, Grace Marie, 95 N. Main
 1939 Sayers, Daniel O'Connell, 278 East
 1933 Shea, Vincent Timothy, 20 E. Main
 1935 Slavin, Joseph E., 798 E. Main
 1906 Smith, Egbert Livingston, 292 W. Main
 1929 Smith, Goodrich Truman, 30 W. Main
 1915 Spicer, Edmund, 292 W. Main
 1931 Staneslow, John Stanislovaitis, 95 N. Main
 1924 Stettbacher, Henry John, 28 Prospect
 1906 Swenson, Andrew Clay, 43 Central Ave.
 1916 Vastola, Anthony Patrick, 103 N. Main
 1920 Webber, Edwin Russell, 95 N. Main

WEST HAVEN

1929 Appell, Harold Seymour, 354 Campbell Ave.
 1938 Chasnoff, John Arthur, 328 Main
 1909 Gilmore, Joseph Leo, 336 Main
 1940 Koster, Leo William, 354 Campbell Ave.
 1904 Kowalewski, Victor Alexander, 597 Campbell Ave.
 1930 Milano, Nicola Antonio, 271 Elm
 1923 O'Connell, William Michael, 295 Main
 1915 Rogers, Platt Harrison, 228 Elm
 1933 Snavely, Marion Elizabeth, 546 Washington Ave.

OUT OF COUNTY

1939 Anderson, Clifford Winthrop, 116 East Elm, Greenwich
 1931 Dryfus, Milton Leopold, 130 W. 57, N. Y. C.
 1921 Dunham, Ethel Collins, 3312 N., N. W., Washington, D. C.
 1937 Eliot, Martha May, 1815 45th, N.W., Washington, D. C.
 1923 Garcia, Alphonso Gilbert, Moosup
 1896 Graves, Frederick George, Bethlehem
 1927 Johnson, Harold Albert, 205 French, Bangor, Maine
 1936 Klumpp, Theodore George, 535 N. Dearborn, Chicago, Ill.
 1934 Lirot, Stephen Leo Robert, 1017 Baltimore, Baltimore
 1917 Merrill, William Truman, 66 Fuller Lane, East Milton, Mass.
 1938 Mucci, Lawrence Adolf, New Britain General Hospital, New Britain
 1936 Pine, Clifford Shepard, 44 Burt Ave., Auburn, N. Y.
 1891 Skinner, Clarence Edward, Cedar Gate, Darien
 1940 Smith, Norman Nathaniel, Bellevue Hospital, N. Y. C.
 1931 Sullivan, Albert Joseph, 3413 Texas Ave., S. E., Washington, D. C.
 1914 Sweet, Grover Cleveland, Veterans' Home and Hospital, Rocky Hill
 1900 Teele, Julia Ernestine, Box 31, Hall-Brooke Sanitarium, Greens Farms, Conn.

NEW LONDON COUNTY ASSOCIATION

President: HUGH F. LENA, 154 Broad St., New London
Vice-President: R. GLEN URQUHART, Uncas-on-Thames, Norwich
Secretary: THOMAS SOLTZ, 26 Main St., New London
Treasurer: SOLAM SEGEL, 257 Main St., Norwich
Councilor: GEORGE H. GILDERSLEEVE, 310 Main St., Norwich
 Annual Meeting, First Thursday in April
 Semi-Annual Meeting, First Thursday in October

COLCHESTER

- 1935 Friedman, Irving, 16 Norwich Ave.
1921 Pendleton, Cyrus Edmund, 13 Main

EAST LYME

NIANTIC

- 1906 Atkinson, Edward, Main
1941 Dart, Frederick Bond, 61 Main
1934 MacLeod, Edith Alice, State Farm for Women
1936 Ward, Lawrence Shapiro, Main

GRISWOLD

JEWETT CITY

- 1937 Ansell, Harvey Berle, 30 N. Main
1937 Barry, Joseph Charles, 3 Ashland
1916 McLaughlin, John Henry, 37 Main
1934 O'Neil, Martin Leo, 8 Park Sq.

GROTON

- 1916 Barnum, Charles Gardner, 230 Thames
1918 Douglass, Edmund Latham, 188 Thames
1934 Hewes, Carlisle Tyson, 242 Thames

LYME

- 1927 Ely, Julian Griffin, R. F. D. No. 2

MONTVILLE

UNCASVILLE

- 1936 Lubchansky, Jacob Harris
1929 Rasmussen, Hans Norman

NEW LONDON

- 1933 Baron, Shirley Harold, 309 State
1933 Becker, Joseph, 325 State
1928 Blank, Eric Henry, 240 Williams
1933 Brosnan, John Francis, 34 Huntington
1927 Burdsall, Elijah Sylvester, 187 Williams
1916 Cheney, George Philip, 179 Montauk Ave.
1936 Comstock, Edward Richard, 106 State
1938 DeAngelis, Louis, 252 Montauk Ave.
1909 Dunn, Frank Martin, 26 Broad
1931 Dyer, Charles Edward, 102 Montauk Ave.
1936 Ferguson, Helen Knox, 508 Montauk Ave.
1906 Gancy, Joseph Matthew, 205 Williams
1934 Gipstein, Edward, 58 Huntington
1939 Hartman, Frederick Bittinger, 58 Huntington
1922 Hendel, Isidor, 50 State
1902 Henkle, Emmanuel Alex, 51 Federal
1934 Henkle, Robert Theodore, 51 Federal
1895 Heyer, Harold Hankinson, 70 Coit
1936 Itzkowitz, Hyman, 325 State
1921 Kaufman, Charles, 308 State
1940 Krinsky, Charles Morris, 325 State
1924 Labensky, Alfred, 85 Federal
1909 Lawson, Stuart Johnston, 116 Federal
1921 Lena, Hugh Francis, 154 Broad
1931 Loiacono, Anthony Joseph, 325 State
1939 Moran, James Patrick, 52 Huntington
1941 Morris, Joyce Shringer, 510 Montauk Ave.
1934 Morse, Willard Jackson, 32 Channing
1921 Murray, Thomas J., 34 Huntington

- 1936 Rapp, Albert Grant, 325 State
1940 Sabloff, Jack, 325 State
1929 Satti, Charles John, 36 Huntington
1941 Savage, Philip Joseph, 86 State
1933 Seoville, Dorothea Haven, 40 Channing
1938 Smilgin, Victor Edward, 265 Williams
1921 Soltz, Thomas, 26 Main
1929 Starr, Richard Mallory, 45 Huntington
1904 Sullivan, Daniel, 833 Ocean Ave.
1940 Sulman, Moris, 203 Montauk Ave.
1899 Taylor, John Clifton, 159 State
1933 Taylor, Robert Nelson, 159 State
1925 Warren, Hill Freeman, 100 State
1922 Wellington, Harold Wentworth, 309 State
1935 Wies, Carl Hendricks, 58 Huntington
1913 Wilson, Frank Emery, 302 State
1938 Woodward, Joseph Cutler, 41 Huntington

NORWICH

- 1910 Agnew, Robert Robertson, 257 Main
1908 Brophy, Edward Joseph, 10 Shetucket
1941 Bryan, William Alvin, Norwich State Hospital
1916 Callahan, John William, 308 Main
1915 Campbell, Hugh Baird, Uncas-on-Thames
1935 Carr, Vandevceer Tabor, State Hospital
1925 Dixon, Henry Campbell, 16 Franklin
1897 Donohue, James Joseph, 43 Broadway
1916 Driscoll, William Thomas, 257 Main
1916 Freeman, Albert Clark, 54 Broadway
1898 Gildersleeve, Charles Child, 310 Main
1927 Gildersleeve, George Harold, 310 Main
1935 Hale, Virginia Anne, State Hospital
1935 Higgins, Harold William, 257 Main
1898 Higgins, Harry Eugene, 257 Main
1938 Kettle, Ronald Harry, Norwich State Hospital
1914 LaPierre, Arnaud Julian, 287 Main
1935 Lukoski, Walter Anthony Francis, 16 Franklin
1936 Mahoney, Joseph John, 99 Main
1922 Manwaring, Ier Jay, Disco Bldg.
1922 Markoff, Kopland Karl, 16 Franklin
1937 Moore, Maurice R., Laurel Hill Rd., R. No. 6
1935 Neumann, Virgil Frank, Uncas-on-Thames
1935 O'Connell, Patrick Henry, 10 Shetucket
1933 Ogden, Arthur White, State Hospital
1936 Osgood, Charles, 257 Main
1934 Quintiliani, Albert, 43 Broadway
1932 Rabinovitch, Allec, 5 Washington
1930 Raymer, John George, 40 Shetucket
1935 Sears, Lewis, 257 Main
1938 Segel, Solam, 257 Main
1929 Suplicki, John William, 255 Main
1921 Sussler, David, 65 Main
1925 Thompson, Clarence George, 257 Main
1931 Urquhart, Robert Glen, Uncas-on-Thames
1935 Weidman, William Harold, Uncas-on-Thames
1932 Wener, William Victor, 130 Main
1941 White, Francis Clark, Uncas-on-Thames

TAFTVILLE

- 1933 Archambault, Henry Allard, 2 N. Second Ave.
1935 Bergendahl, Harold Andrew, 1 S. Second Ave.

OLD LYME

BLACK HALL

1909 Devitt, Ellis King

STONINGTON

1934 Haliday, Earle George, 168 Water

1912 Williams, Charles Mallory, 174 Water

MYSTIC

1907 Allyn, Louis Maxson, 22 Library

1941 Fowler, Roger Nathanael, 5 Library

1894 Gray, William Henry, 27 Willow

1932 Leon, Abraham Joseph, 21 E. Main

1915 Maine, Thurman Park, 64 Washington

1941 Ryley, Roger Noyes, 35 Willow

WATERFORD

1913 O'Brien, John Francis, "The Seaside"

OUT OF COUNTY

1932 Griswold, Matthew, 154 Armory, New Haven

1937 Lund, Frederick Albert, Brooklyn Hospital, DeKalb Ave. and Ashland Pl., Brooklyn, N. Y.

1924 Raynolds, Randolph, Graduates Club, New Haven

1931 Thompson, Lawrence Everett, Undercliff, Meriden

1933 Whitty, Charles Aloysius, Cedarcrest, Hartford

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Annual Meeting, Third Tuesday in April

Semi-Annual Meeting, Third Tuesday in October

COVENTRY

SOUTH COVENTRY

1891 Higgins, William Lincoln

ELLINGTON

1940 Levine, Leonard Warren

MANSFIELD

MANSFIELD DEPOT

1934 Clow, Henry Leon, State Training School and Hospital

1930 Hankins, Melissa Millner, State Training School and Hospital

1935 Haviland, Walter Childs, State Training School and Hospital

1940 Leonard, Robert John, State Training School and Hospital

SOMERS

1921 Thayer, Ralph Bruce, Main

STAFFORD

STAFFORD SPRINGS

1908 Hanley, John Patrick, 15 Church

1941 Luckner, Wendelin George

1921 Moore, Harry, 46 E. Main

1935 Schiavetti, Alfred, 11 Church

VERNON

ROCKVILLE

1937 Beckwith, Donald Macfarlane, 68 Prospect

1933 Burke, Francis Henry, 27 Park

1908 Dickinson, Francis McLean, 38 Elm

1923 Ferguson, Roy Cameron, 57 Union

1918 Flaherty, John Edward, 42 Elm

1921 Metcalf, Elliott Harrison, 50 Elm

1897 O'Loughlin, Thomas Francis, 26 N. Park

1931 Schneider, William, 34 Union

WILLINGTON

WEST WILLINGTON

1928 Converse, Frank Benjamin

OUT OF COUNTY

1918 LaMoure, Charles TenEyck, Windham Center

WINDHAM COUNTY ASSOCIATION

President: MORTON H. CHAPNICK, 168 Main St., Putnam*Vice-President:* ARTHUR D. MARSH, Hampton*Secretary:* RALPH L. GILMAN, University of Connecticut, Storrs*Councilor:* ROBERT C. PAINE, Thompson

Annual Meeting, Third Thursday in April

Semi-Annual Meeting, Third Thursday in October

CANTERBURY

1936 Baldwin, Helen

HAMPTON

1914 Marsh, Arthur Drought

KILLINGLY

DANIELSON

1935 Chartier, Gerard Marcel, 136 Main

1928 Garein, Cecil Redvers, 7 Broad

1940 Laakso, Andrew Olavi, 27 Broad

1909 Perreault, Joseph Napoleon, 43 Main

1919 Tanner, Warren Avery, 36 Academy

1920 Todd, Frank Paige, 178 Main

MOOSUP

1940 Couture, Arthur Joseph, 19 S. Main

PLAINFIELD

1903 Chase, Arthur Alverdo, Railroad Ave.

1933 Gulino, Angelo James

PUTNAM

1934 Chapnick, Morton Herman, 168 Main

1930 Dean, Florence Franklin, 32 S. Main

1927 LaPalme, Joseph Antonio, 158 Main

1941 Margolick, Moses, 80 Main

1921 Phillips, Karl Tristram, 66 Main

1922 Russell, John Jarvis, Bridge and Main

1934 Shepard, William Mac, 66 Main

THOMPSON

1903 Paine, Robert Child

NORTH GROSVENORDALE

1936 Roy, Joseph Lambert

WINDHAM

WILLIMANTIC

- 1935 Arnold, Morton, 781 Main
 1939 Basden, Edward Herbert, 199 Church
 1939 Carter, George Howard, 29 North
 1901 Girouard, Joseph Arthur, 19 Union
 1896 Hills, Laura Heath, 727 Main
 1913 Jenkins, Charles Albert, 715 Main
 1928 Kinney, Kenneth Kyle, 29 North
 1925 Ottenheimer, Edward Joseph, 29 North
 1932 Rafferty, Brac, 807 Main
 1916 Riordan, Michael Davitt, 29 North
 1936 Roch, George Emile, 33 Church
 1937 Rothblatt, Reuben, 672 Main

- 1914 Shea, Richard Edward, 850 Main
 1914 Smith, Fred Morse, 736 Main
 1935 Vernon, Sidney, 828 Main

WOODSTOCK

EAST WOODSTOCK

- 1913 Pike, Ernest Reginald

OUT OF COUNTY

- 1910 Downing, Francis, 287 Main, Norwich
 1883 Foster, Warren Woden, 4000 Cathedral Ave., Washington, D. C.
 1932 Gilman, Ralph Lawrence, Storrs
 1938 Lambert, George S., 4 Reynolds Hill, Mystic
 1929 Spector, Nathan, 60 Broad, Lynn, Mass.

ALPHABETICAL ROLL OF MEMBERS

With date and place of graduation

- Aaronson, M. S., Univ. of Bellevue, '13, Ansonia
 Abbey, E. A., B.A., Mt. St. Mary's, '26, Georgetown, '30, New Haven
 Abrahams, M., Tufts, '31, New Canaan
 Abrashkin, M. D., Maryland, '32, New Haven
 Adam, F. S., Ph.B., Boston U., '21, Yale, '25, No. Canaan
 Adams, M., A.B., Bryn Mawr, '23, Johns Hopkins '29, Riverside
 Adzima, J. M., Maryland, '27, Bridgeport
 Affinito, T., B.S., Yale, '26, McGill, '31, Meriden
 Agnew, R. R., Yale, '08, Norwich
 Aiello, L. J., B.S., Fordham, '31, Boston U., '35, New Haven
 Aiken, S., Toronto, '29, Manchester
 Akerson, I. B., B.S., Iowa, '22, Iowa, '25, Bridgeport
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 Allen, H. E., B.A., Bowdoin, '15, Bowdoin, '19, Waterbury
 Allen, H. S., Yale, '04, Woodbury
 Allen, M. F., Med. Chi., Phila., '95, New Haven
 Allen, W. M., B.A., Haverford, '16, Johns Hopkins, '20, Hartford
 Alling, A. N., B.A., Yale, '86, P. & S., N. Y., '91, New Haven
 Allyn, L. M., Pa., '03, Mystic
 Alpert, M., B.S., Yale, '28, Bridgeport
 Alpert, R. H., Yale, '13, New Haven
 Alu, A. F., Yale, '20, Ansonia
 Amatruda F. G., B.A., Yale, '20, Yale, '23, New Haven
 Amos, I. L., McGill, '26, Danbury
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 Anderson, C. W., A.B. Colgate, '30, Harvard, '34, Greenwich (New Haven Co.)
 Andrus, O. B., B.A., Dartmouth, '28, Univ. of Bellevue, '32, Devon
 Andrews, E. M., Maine, '25, Harvard, '30, Hartford
 Angus, L. R., B.A., Toronto, '25, Toronto, '28, Hartford
 Ansell, H. B., Tufts, '32, Jewett City
 Antell, M. J., B.S., Middlebury, '25, Vt., '29, Bridgeport
 Antupit, L., B.S., Trinity, '19, Jefferson, '23, Hartford
 Appell H. S., Tufts, '27, West Haven
 Appell, P. H., Univ. of Bellevue, '23, Bristol
 Apsel, A., Ph.G., Brooklyn Coll. Phar., '13, L. I. Coll. Hosp., '18, Bridgeport
 Apter, H., B.A., Geo. Wash., '31, Geo. Wash., '34, Hartford
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 Arnold, H. B., B.A., Yale, '23, Yale, '26, New Haven
 Arnold, H. S., B.A., Yale, '00, Yale, '03, New Haven
 Arnold, M., B.A., Harvard '25, Harvard, '29, Willimantic
 Arons, M. R., Ph.B., Yale '25, Md., '30, Hartford
 Ashcroft, A. D., P. & S., N. Y., '35, Stratford
 Ashley, H. C., Va., '26, New Hartford
 Atha, H. G., Ph.B., Brown, '27, Tufts, '34, Thomaston
 Atkins, S. M., Tufts, '22, Waterbury
 Atkinson E., Vt., '93, Niantic
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 Austin, A. E., B.A., Amherst, M.A., Amherst, '04, Jefferson, '05, Old Greenwich
 Awdziejewicz, F. J., B.S., Yale, '29, Yale, '32, Stamford
 Ayres, P. B., Toronto, '32, Cos Cob
 Backer, M., Yale, '24, Bridgeport
 Backus, H. S., L. I. Coll. Hosp., '03, Hartford
 Bailey, H., B.A., Yale, '19, Md., '22, Hartford
 Bailey, N. H., P. & S., Balt., '11, Hartford
 Baker, P. G., B.S., Vermont, '30, Vermont, '33, Winsted
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 Baldwin, C. T., Bellevue, '83, Derby
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 Baldwin, W. P., B.A., Yale, '88, Yale, '90, N. Y. Hom., '91, New Haven
 Balletto, V., B.S., Yale, '29, Tufts, '33, East Haven
 Bancroft, H. A., Albany, '16, Hartford
 Banks, D. T., Fordham, '12, Bridgeport
 Bannon, F. M., Vt., '28, Stamford
 Barald, F. C., B.S., Univ. of Conn. '32, Boston, '36, New Haven
 Barber, W. L., Jr., B.A., Yale, '03, Univ. of Bellevue, '07, Waterbury
 Barker, A. J., Bellevue, '97, Torrington
 Barker, C., Dartmouth, '13, New Haven
 Barker, N. J., Toronto, '26, Hartford
 Barnes, F. H., N. Y. Hom., '96, Stamford
 Barnes, W. S., Ph.B., Yale, '95, Yale, '97, New Haven
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 Bartlett, C. J., B.A., Yale, '92, M.A., Yale, '94, '95, New Haven
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 Bassin, A. L., Rochester, '30, New Haven

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 Carter, G. H., A.B., Amherst, '31, P. & S., N. Y., '35, Willimantic
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 Cheney, B. A., B.A., Yale, '88, Yale, '90, New Haven
 Cheney, G. P., Md. Med., '13, New London
 Cheney, M. L., Univ. Vt., '17, Bridgeport
 Chernaik, S. J., Jefferson, '16, New Britain
 Childs, A. E., N. Y. U., '96, Litchfield
 Chipman, S. S., B.A., Acadia, '24, McGill, '28, Norwalk
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 Clark, W. T., Queens U., '34, Bridgeport
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 Clarke, R., deB., B.A., N. Y. U., '04, Johns Hopkins, '08, Hartford
 Clarke, W. C., P. & S., N. Y., '99, Cornwall Bridge
 Clason, F. P., B.A., Bates, '11, Harvard, '15, Hartford
 Cleary, H. J., Tufts, '29, Watertown
 Clifford, M. L., B.A., Univ. Colorado, '30, C.P.H., Johns Hopkins, Univ. Colorado, '33, Hartford
 Clifton, H. C., Univ. Pa., '01, W. Hartford
 Climan, M., B.A., Yale, P. & S., N. Y., '15, Hartford
 Climo, S., Ohio State, '29, New Haven
 Close, J. F., B.A., Colgate, '21, P. & S., N. Y., '25, Greenwich
 Clow, H. L., Tufts, '14, Mansfield Depot
 Coates, S. P., Lehigh, '30, Maryland, '34, Suffolk
 Cobb, A. E., Yale, '98, Canaan (Hartford Co.)
 Cobey, J. F., Ph.B., Yale, '12, Yale, '16, New Haven
 Cochran, L. B., Univ. Pa., '93, Hartford
 Cody, G. R., Georgetown, '36, South Norwalk
 Coffey, J. R., A.B., Yale, '03, Yale, '07, New Haven
 Cofrances, L. W., Jefferson, '23, New Haven
 Cogan, G. E., B.S., Georgetown, '21, Georgetown, '23, Hartford
 Cogland, J. L., Univ. of Vt., '31, Univ. of Vt. Coll. of Med., '34, Hartford
 Cognetta, J. J., Univ. of Vt., '36, Stamford
 Cogswell, E. S., Harvard, '12, Hartford
 Cogswell, L. P., A.B., Univ. Maine, '27, Harvard, '33, Hartford
 Cohane, J. J., Yale, '98, New Haven
 Cohane, T. F., Yale, '97, New Haven
 Cohen D. J., Yale, '32, Meriden
 Cohen, J., B.A., Coll. City N. Y., '94, Eclectic, N. Y., '09, Trenton, N. J. (Fairfield Co.)
 Cohen, W., Ph.B., Yale, '20, Yale, '23, New Haven
 Cohn, S. H., Boston, '30, '34, Hartford
 Collins, J. O., Baylor, '29, Waterbury
 Collins, W. F., Yale, '04, New Haven
 Colwell, H. S., B.S., Colgate, '10, Johns Hopkins, '14, New Haven
 Comfort, C. W., Jr., B.A., Yale, '07, Yale, '11, New Haven
 Compson, F. E. M., B.A., Geo. Wash., '19, Boston U., '20, Middletown
 Comstock, E. R., B.S., Tufts, '30, Tufts, '33, New London
 Conklin, C. S., Fordham, '16, Bridgeport
 Conlon, W. L., Jefferson, '36, Ph.B., Providence Coll., '32, Manchester
 Connolly, A. J., B.S., Georgetown, '24, Georgetown, '28, New Haven
 Connolly, J. P., Georgetown, '36, Stamford
 Connor, J. J., B.S., Trinity, '26, Yale, '30, Hartford
 Connor, G. M., Villanova, '31, Boston Univ., '35, Plantsville
 Connors, E. R., Boston U., '31, Bridgeport
 Conroy, M. J., B.A., Yale, '18, Yale, '20, Meriden
 Conte, H. A., L. I. Coll. Hosp., '12, New Haven
 Conte, M. G., Providence, '30, Royal Univ. of Naples, '35, New Haven
 Converse, F. B., Eclectic, Cinn., '94, West Willington
 Cook, G. F., Tufts, '23, Plainville
 Cook, R. J., B.A., Iowa, '09, Johns Hopkins, '13, New Haven
 Cooley, C. M., Yale, '08, New Britain
 Coon, W. H., Bellevue, '97, Bridgeport
 Corbett, H. J., Tufts, '29, Waterbury
 Corcoran, M. A., Tufts, '30, Hartford
 Corey, W. VanA., Geo. Wash., '33, Hamden
 Cornelio, F. J., B.S., Niagara, '30, Georgetown, '34, Winsted
 Corrandino, C. L., Tufts, '29, New Haven
 Corridon, J. D., B.A., Fordham, '24, Georgetown, '28, S. Norwalk
 Costanzo, J. J., Univ. Ill., '05, Stamford
 Costello, H. N., B.A., Yale, '06, Johns Hopkins, '10, Hartford
 Cotterio, T., B.S., Yale, '26, Waterbury
 Couch, A. R., B.A., Amherst, '01, N. Y. Homeo., '05, Hartford
 Couch, F. H., B.A., Harvard, '27, Yale, '30, Cromwell
 Couch, M. W., B.A., Smith, '18, Univ. Minn., '27, Cromwell
 Couture, A. J., A.B., Assumption Coll. Boston Univ., '32, Moosup
 Cox, R. B., McGill, '02, Collinsville
 Coyle, A. E. M., Wom. Med., Pa., '12, Windsor Locks
 Coyle, B. J., St. Bonaventure, '11, Georgetown, '18, Windsor Locks
 Cragin, D. B., Harvard, '02, Hartford
 Craighill, M. D., B.A., B.S., Wisconsin, '20, Johns Hopkins, '24, Philadelphia, Penna (Fairfield Co.)
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 Crane, J. E., B.S. Vermont, '36, Vermont, '39, Stamford
 Crane, R. W., Yale, '05, Stamford
 Crawley, G. A., Temple, '28, West Hartford
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 Creaturo, N. E., B.A., Columbia, '28, Boston U., '31, Bridgeport
 Crook, J. B., N. Y. Homeo., '13, East Haddam
 Crosby, E. H., B.A., Amherst, '24, Yale, '28, Hartford
 Culotta, C. S., B.S., Yale, Yale, '28, New Haven
 Cunningham, J. M., B.S., Univ. Texas, '23, Univ. Texas, '26, Hartford
 Cunningham, R. D. M., B.S., Tufts, '26, Yale, '30, Stamford
 Curley, W. H., Cornell, '08, Bridgeport
 Curran, H. J., Tufts, '24, Thomaston
 Curran, P. J., P. & S., N. Y., '01, Bridgeport
 Curtis, B. H., Columbia, '33, P. & S., N. Y., '36, Hartford
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 Daley, L. W., McGill, '30, Med. & Sur., McGill, '30, New Britain
 Dallas, M., Boston U., '22, New Haven
 Dalton, G. H., Yale, '12, New Britain
 Daly, C. W., P. & S., Balt., '10, Hartford
 Daly, W. P., B.S., Georgetown, '15, Georgetown, '17, Hartford
 D'Ambruoso, D. C., Columbia, '36, Derby
 D'Amico, M., B.S., Yale, '28, Yale, '31, New Haven
 Damiani, R. A., Tufts, '33, Waterbury
 Danaher, T. J., B.S., Yale, '25, Yale, '28, Torrington
 D'Andrea, F. H., B.S., Yale, '26, Yale, '29, Stamford
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 Darrow, J. E., Tufts, '28, New Britain
 Dart, F. W., Maryland, '23, New Haven
 Davenport, A. K. P., Md. Coll. S. C., '03, Syracuse U., '17, Hartford
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 Davis, J. B., Kansas, '33, New Haven
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 Davis, T. F., Tufts, '21, Fairfield
 Dawson, L. M., Queen's, '09, Hartford
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 Day, R. S., N. Y. Med. Coll., '06, New Milford
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- DeBonis, D. A., B.A., Victor Immanuel College, Naples, '84, Univ. Naples, '90, Hartford
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- Delohery, C. L., Ph.B., Villanova, Temple, '26, Danbury
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- DelVecchio, L. F., Georgetown, '31, Bridgeport
- Deming, C. D., B.A., Yale, '07, Johns Hopkins, '10, Hartford
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- Deming, C. L., B.A., Bowdoin, '10, Yale, '15, New Haven
- Deming, D. B., P. & S., N. Y., '01, Waterbury
- Deming, E. A., Ph.B., Yale, '04, Johns Hopkins, '08, Hartford
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- Denne, T. H., Univ. Vt., '05, West Hartford
- Dennehy, W. J., B.A., Yale, '15, Yale, '18, New Haven
- DePasquale, F. L., Univ. Pa., '26, Hartford
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- Derwin, J. J., B.S., St. Bonaventure, Georgetown, '30, Winsted
- Desmond, W. F., B.A., Univ. Mich., '21, Yale, '25, Newtown
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- DeVita, M. J., Vanderbilt, '28, Hartford
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- DeWitt, E. N., Univ. Pa., '17, Bridgeport
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- Dichter, C. L., Md. Med., '05, Stamford
- Dichter, I. S., B.A., Columbia, '27, Jefferson, '31, Stamford
- Dickinson, F. McL., Ph.B., Yale, '00, P. & S., N. Y., '05, Rockville
- Diefendorf, A. R., B.A., Yale, '94, Yale, '96, New Haven
- Dignam, B. S., B.A., Trinity, '30, Yale, '35, Thompsonville
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- Dinsmore, W. W., B.S., Univ. Ala. Poly. Inst., Johns Hopkins, '07, Hartford
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- DiStasio, F., B.S., Maryland, '29, Maryland, '33, New Haven
- Dixon, H. C., B.A., Bowdoin, '14, Bowdoin, '17, Norwich
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- Donner, S., B.A., Yale, '18, Cornell, '33, Hartford
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- Donohue, J. J., P. & S., Baltimore, '96, Norwich
- Donovan, W. F., B.S., Conn. S., '26, Boston U., '31, Hartford
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- Dowd, M. J., Balt. Med., '01, Thompsonville
- Downing, F., Balt. Med., '08, Norwich (Windham Co.)
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- Dreher, S. M., B.S., Pennsylvania, '21, Temple, '37, Derby
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- DuBois, R. L., Maryland, '35, Waterbury
- Dudac, T. W., B.S.M., Georgetown, '31, Georgetown, '33, Southington
- Duffy, L. T., B.S., Conn. St., '30, Tufts, '34, Hartford
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- Duffy, W. C., B.A., Wake Forest, '10, Johns Hopkins, '14, New Haven
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- Dunn, G. W., Balt. Med., '09, New Britain
- Dunne, E. P., Holy Cross, '12, Univ. Maryland, '18, Unionville
- Dunne, R. E., B.A., Catholic Univ., Harvard, '19, Hartford
- Durkee R. E., Jr., Harvard, '29, Harvard, '36, Hartford
- Duzmati, P. P., Jefferson, '36, Bridgeport
- Dwyer, P. J., N. Y. U., '97, Waterbury
- Dwyer, W., B.S., Trinity, '09, Johns Hopkins, '13, Hartford
- Dye, J. S., B.A., Vanderbilt, '00, P. & S., N. Y., '15, Waterbury
- Dyer, C. E., Tufts, '28, New London
- Earle, B. B., B.A., Baylor, '25, Rush, '30, Glastonbury
- Eckert, G. R., Tufts, '33, Danbury
- Eddy, M. H., Yale, '29, A.B., Harvard, '35, Bridgeport
- Edgar, K. J., B.A., Oregon, Oregon, '31, Bridgeport
- Edlin, C., Tufts, '25, Waterbury
- Edson, R. H., B.S., Princeton, Cornell, '35, Shelton
- Egan, J. J., Univ. Md., '07, Waterbury
- Egee, J. B., B.S., Hahne., '30, Hahne., '34, Sandy Hook
- Eimas, A., Tufts, '30, Bridgeport
- Eliot, M. M., Johns Hopkins, '18, Washington, D. C. (New Haven Co.)
- Elliot, K. G., Tufts, '26, Hartford
- Elliott, G. A., Toronto U., '24, Brattleboro, Vt. (Middlesex Co.)
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- Ellis, F. D., Jr., B.A., Univ. Pa., '15, Univ. Pa., '18, Farmington
- Ellison, F. S., Hamilton, '30, Yale, '34, Hartford
- Ellrich, D. L., B.A., Harvard, '24, Jefferson, '28, Westport
- Elmer, E. O., P. & S., Balt., '94, Hartford
- Ely, J. G., B.S., Wesleyan, '17, Harvard, '23, Lyme
- Ematrudo, F. R., Eclectic, Conn., '21, Hamden
- Emmett, F. A., Yale, '02, Hartford
- Enander, F. C., Tufts, '22, New Britain
- Enders, T. B., B.A., Yale, '88, P. & S., N. Y., '91, Mystic (Hartford Co.)
- Engelke, C., P. & S., N. Y., '02, Waterbury
- English, C. F., B.S., St. Louis U., '12, Winsted
- Errico, L., B.A., Yale, '18, Yale, '21, New Haven
- Esposito, J. J., B.A., Yale, Columbia, '37, New York City (Fairfield Co.)
- Evans, T. S., B.A., Yale, '17, B.S., Columbia, '19, P. & S., N. Y., '21, New Haven
- Evarts, J., B.A., Vassar, '24, P. & S., N. Y., '29, Cornwall Bridge
- Ellwell, J. W., Harvard, '36, Farmington
- Fabricant, S. E., Jefferson, '19, Waterbury
- Fagan, F. X., Ph.B., Brown, '29, Cornell, '33, Hartford
- Fancher, H. W., B.S., St. Johns, '21, Univ. Md., '25, Thompsonville
- Farland, V. L., B.A., Joliet, '20, Montreal U., '25, Hartford
- Fauver, E., P. & S., N. Y., '09, Middletown
- Fawcett, G. G., Cornell, '15, South Norwalk
- Fay, W. J., B.A., '10, Harvard, '14, Hartford
- Fekety, S. H., Tufts, '30, Middletown
- Felt, P. R., B.A., Dartmouth, Dartmouth, '10, Middletown
- Felty, A. R., B.A., Yale, '16, Johns Hopkins, '20, Hartford
- Fenney, P. W., B.S., N. Y. U., '27, Tufts, '31, New Haven
- Ferguson, H. K., B.S., Conn. Coll., '25, N. Y. U. & Bellevue, '32, New London
- Ferguson, R. C., B.A., Yale, '18, Yale, '20, Rockville
- Ferguson, R. J., Hahn, Phila., '89, New Haven
- Filson, R. M., B.A., Queen's, '13, Queen's, '15, Garden City, L. I., N. Y. (Hartford Co.)
- Fincke, C. L., B.A., Harvard, '24, Harvard, '28, Stamford
- Findorak, F. G., B.S., Georgetown, '32, Stratford
- Fine, B., B.S., Univ. Pa., '28, Jefferson, '32, Stamford
- Fine, J., Univ. Pa., '31, Stamford
- Finkelstein, W., Harvard, '34, Waterbury
- Finkelstone, B. B., P. & S., Balt., '10, Bridgeport
- Finley, G. C., Tufts, '24, Hartford
- Finn, A. J., B.A., Bowdoin, '17, Bowdoin, '21, Waterbury
- Finn, E. J., Yale, '10, Shelton
- Fischer, W. J. H., Yale, '11, Milford
- Fisher, J. W., Wom. Med., Pa., '93, Middletown
- Fiske, M., B.A., Vassar, Boston U., '27, Stamford
- Fiskio, P. W., B.S., Yale, '24, Yale, '27, New Haven
- FitzGerald, C. J., Univ. Vt., '98, New Haven
- Fitzpatrick, E. E., Ph.G., R. I. Coll. Phar., '07, Univ. Md., '15, Waterbury
- Fitzpatrick, W. F., Cornell, '38, Norwalk
- Flaherty, C. V., Yale, '10, Hartford
- Flaherty, J. E., Georgetown, '08, Rockville
- Flanagan, E. D., U. of Dayton, '31, St. Louis, '35, South Norwalk
- Flanagan, W. F., Fordham, '17, New Britain
- Fleck, H. W., Jefferson, '96, Bridgeport
- Flynn, C. T., Yale, '11, New Haven
- Flynn, D. A., Yale, '05, New Haven
- Flynn, H. A., B.A., Yale, '23, Yale, '27, New Haven
- Flynn, W. H., Univ. Md., '16, Bristol
- Foley, F. E., B.A., Holy Cross, '08, Yale, '14, New Haven
- Foley, F. X., A.B., Boston U., '34, Bridgeport
- Foot, C. J., B.A., Yale, '83, M.A., Yale, '90, Harvard, '87, New Haven
- Formichella, J. B., Univ. Naples, '98, Bridgeport
- Foster, E. W., B.A., Kansas, '16, Harvard, '24, Meriden
- Foster, J. H., B.S., Colby, '13, Univ. Pa., '17, Waterbury
- Foster, L. C., B.A., Univ. Kansas, '19, Harvard, '23, New Haven
- Foster, W. W., Harvard, '82, Washington, D. C. (Windham Co.)

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 Fox, G. G., B.S., Yale, '30, Harvard, '34, Meriden
 Fox, J. C., Jr., B.A., Williams, '16, Johns Hopkins, '20, New Haven
 Frank, H. S., B.A., Wesleyan, '21, P. & S., N. Y., '24, Middletown
 Freedman, B. P., Ph.B., Yale, '17, Yale, '20, New Haven
 Freeman, A. C., Univ. Vt., '13, Norwich
 Freeman, D., Ph.B., Yale, '20, Yale, '24, New Haven
 Freiheit, J. M., B.S., Yale, '24, Yale, '27, Waterbury
 Friedberg, S., B.S., Coll. City N. Y., '19, L. I. Coll. Hosp., '28, Stamford
 Friedman, I., Geo. Wash., '31, Colchester
 Friedman, I., B.S., C. C. N. Y., '29, Yale, '33, New Haven
 Friedman, N. H., B.S., Tufts, Tufts, '33, Stratford
 Friedman, S., Harvard, '26, Boston U., '31, Newtown
 Friend, A. E., Queen's, '22, South Manchester
 Friery, C. M., B.A., Harvard, '25, Boston U., '29, Hartford
 Frost, L. H., Univ. Vt., '13, Plainville
 Frothingham, J. G., A.B., Harvard, Harvard, '35, New Canaan
 Fruin, J. W., L. I. Coll. Hosp., '08, Waterbury
 Fry, C. C., Northwestern, '24, New Haven
 Fulstow, M., Tufts, '20, Fairfield
 Furniss, H. W., Howard, '91, Hartford
 Gaberman, D., P. & S., N. Y., '20, Hartford
 Gade, C. J., Yale, '10, Bridgeport
 Gaetz, T. H., McGill, '24, Shelton
 Gaffney, C. B., B.S., Pitt., Loyola, '30, Bridgeport
 Gaffney, J. J., Loyola, '30, Danbury
 Galinsky, D., Trinity, '32, Tufts, '36, Hartford
 Gallivan, J. N., B.A., Tufts, '32, Tufts, '35, East Hartford
 Gallo, F., B.S., St. Bonaventure, '30, Jefferson, '34, Winsted
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 Gandy, R. A., B.S., Univ. Va., Univ. Va., '27, Stamford
 Gandy, R. R., Univ. Pa., '99, Stamford
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 Gardner, C. W., Univ. Md., '01, Bridgeport
 Gardener, N. H., Tufts, '34, East Hampton
 Garland, R. B., P. & S., Balt., '13, Hartford
 Garlick, G. B., Yale, '12, Bridgeport
 Garofalo, M. L., Yale, '29, Royal Univ. of Naples, '35, New Haven (Hartford Co.)
 Garston, L. E., St. Louis U., '30, Torrington
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 Gerstl, B., Vienna, '27, New Haven
 Gettings, J. A., Jefferson, '16, New Haven
 Giamarino, H. J., Univ. Me., '06, New Haven
 Gianotti, C. C., Albany Med., '18, New Haven
 Gibson, C. B., Atlanta Med., '14, Meriden
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 Gildea, E. F., A.B., Colorado, '20, Harvard, '24, New Haven
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 Gildersleeve, C. C., Yale, '96, Norwich
 Gildersleeve, G. H., Ph.B., Brown, '19, Yale, '23, Norwich
 Giles, N. W., Univ. Vt., '21, Stamford
 Gill, M. H., Yale, '96, Hartford
 Gillespie, H., Trinity, '29, Jefferson, '34, Hartford
 Gills, W. L., B.A., Randolph Macon, '05, John Hopkins, '12, Hartford
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 Giorgio, N. A., B.S., Dartmouth, '22, L. I. Coll. Hosp., '25, Hartford
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 Gissler, N. E., Yale, '28, Middletown
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 Giuliano, S., B.S., Yale, '26, Tufts, '30, Hartford
 Glass, G. C., B.S., Trinity, '27, Yale, '31, Hartford
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 Glazer, M., Ph.B., Yale, '18, Tulane, '22, New Haven
 Glazier, J. R., Harvard, '22, West Hartford
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 Godfrey, E. J., Georgetown, '15, Waterbury
 Godfrey, W. T., Cornell, '07, Stamford
 Godfried, M. S., A.B., Yale, '32, Yale, '36, New Haven
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 Goldberg, I. S., B.A., Cath. U., '28, Creighton, '33, Torrington
 Goldberg, S. J., Yale, '07, New Haven
 Goldberg, S. J., Jr., B.A., Yale, '32, Harvard, '36, New Haven
 Goldenberg, J. J., Dalhousie, '26, Hartford
 Goldman, G., Yale, '10, New Haven
 Goldschmidt, M., Trinity, '34, Virginia, '38, New Britain
 Goldstein, M., Yale, '24, New Haven
 Goldstein, R. M., B.S., Harvard, '21, Johns Hopkins, '30, New Haven
 Goldys, W. M., Yale, '09, Waterbury
 Goldys, F. M., B.A., Harvard, Tufts, '26, Danbury
 Good, W. M., Yale, '09, Waterbury
 Goodell, R. A., Ph.B., Brown, '24, Harvard, '28, Hartford
 Goodenough, E. W., B.A., Yale, '87, Yale, '93, Waterbury
 Goodrich, C. A., B.S., Mass. Agr. Coll., '93, P. & S., N. Y., '96, Hartford
 Goodrich, W. A., B.A., Yale, '31, Columbia, '35, Waterbury
 Gordon, W. F., L. I. Coll. Hosp., '96, Danbury
 Gore, M. A., B.A., Geo. Wash., '14, Univ. Md., '18, Bristol
 Gorham, G. V., A.B., M.A., U. of Mich., '30, Norwalk
 Gosselin, G. A., B.A., Laval, '11, Univ. Vt., '15, Hartford
 Gould, M. M., Tufts, '31, Hartford
 Gourlie, N. W., Yale, '27, Harvard, '31, Thompsonville
 Grady, J. F., P. & S., N. Y., '32, Stamford
 Grannis, I., Yale, '96, Old Saybrook
 Granoff, M. A., A.B. Oklahoma, '33, Chicago, '37, New Haven
 Grant, A. S., B.S., Wesleyan, Univ. & Bellevue, '08, New Britain
 Grant, R. F., B.S., N. Y. S. Col. Forestry, '32, M.A., Wesleyan, '34, Albany, '38, Cromwell.
 Grau, L. C., Dartmouth, '12, Hartford
 Graves, F. G., Yale, '92, Bethlehem (New Haven Co.)
 Gray, A. S., Bellevue, '15, West Hartford
 Gray, W. H., P. & S., N. Y., '89, Mystic
 Green, H. H., A.B. Clark Univ., '27, Johns Hopkins, '31, South Norwalk
 Green, J. H., Univ. & Bellevue, '13, Waterbury
 Green, W. F., B.S., Harvard, '28, Hartford, '32, Newtown
 Greenberg, A., B.S., N. Y. U., L. I. Coll. Hosp., '32, Old Saybrook
 Greenhouse, B., Ph.B., Yale, '18, Yale, '21, New Haven
 Greenspun, D. S., Ph.B., Yale, '21, Yale, '25, Bridgeport
 Grenon, O. A., B.S., Georgetown, '31, Georgetown, '33, East Haven
 Grevatt, K. L., Dartmouth, '30, A.B., Penna., '35, Redding
 Griffin, D. P., Jefferson, '14, Bridgeport
 Grigas, J. E., Tufts, '36, Bethel
 Griggs, J. B., Jr., B.A., Yale, '23, Yale, '26, West Hartford
 Grillo, V. J., B.S., Yale, '29, Yale, '33, Hamden
 Griswold, A. S., Yale, '21, Bridgeport
 Griswold, C., Yale, '24, Bridgeport
 Griswold, E. M., Yale, '32, Glastonbury
 Griswold, M., B.A., Yale, '25, New Haven (New London Co.)
 Griswold, M. H., Univ. Vt., '13, Hartford
 Groark, J. A., B.A., Yale, '21, Yale, '24, New Haven
 Groark, O. J., Med. Chi., Phila., '16, Bridgeport
 Grodin, H. W., Yale, '17, New Haven
 Grossman, W., Univ. of Berlin, '21, Hartford
 Grosvenor, F. L., Buffalo U., '00, Hartford
 Grout, S. P., Univ. Vt., '04, Newtown
 Grower, J. H., B.S., Univ. Neb., '24, Univ. Neb., '25, Middletown
 Gudger, J. R., Davidson, '25, Virginia, '30, Hartford
 Guida, F. P., B.S., Yale, '31, Yale, '34, New Haven
 Gulino, A. J., Tufts, '31, Plainfield
 Gura, G. M., B.S., Loyola, '30, Loyola, '31, Southington
 Haberlin, C. E., B.S., W. Va., Med. Coll. Va., '24, Stratford
 Hale, F., B.S., Amherst, '05, P. & S., N. Y., '09, Bridgeport
 Hale, V. A., Univ. Texas, '22, Norwich

- Haliday, E. G., Queen's, '27, Stonington
 Hall, L., B.A., Harvard, '20, Harvard, '24, Hartford
 Hall, M. I., Edinburg, '34, Bristol
 Hall, R. W., Yale, '07, Bridgeport
 Hall, W. C., B.A., U. of Texas, '26, U. of Penna., '30, Hartford
 Hall, W. E., B.A., Yale, '22, Yale, '25, Meriden
 Hamilton, J. S. M., McGill, '26, Stamford
 Hanchett, H. B., Jefferson, '05, Torrington
 Hankin, M. A., B.S., Yale, '26, L. I. Coll., '33, New Haven
 Hankins, M. M., B.A., Salem, '17, Univ. Pa., '25, Mansfield Depot
 Hanley, J. P., Cornell, '06, Stafford Springs
 Hanrahan, W. R., P. & S., Balt., '05, Bristol
 Hansell, H. R., B.A., Univ. Pa., '23, Univ. Pa., '27, Sharon
 Hardenburg, D. B., A.B., Yale, Harvard, '34, Bridgeport
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 Harrington, A. T., B.A., Yale, '94, Harvard, '10, West Hartford
 Harris, B. R., Ph.B., Yale, '19, Yale, '22, New Haven
 Harris, J. S., Yale, '32, New Haven
 Harris, L. D., Tufts, '34, Hartford
 Harrison, E. R., Yale, '26, New Haven
 Harrison, F. M., A.B., Holy Cross, '17, Jefferson, '22, Stamford
 Harrison, J. F., Jefferson, '03, Stamford
 Harshbarger, I. L., Univ. Va., '22, Bridgeport
 Hart, J. C., B.S., Yale, '27, Yale, '30, New Haven
 Hart, C. J., Hahne, Phila., '03, New Britain
 Hartman, F. B., A.B., Hamilton, '30, Harvard, '34, New London
 Harvey, C. C., B.S., Wesleyan, '12, Cornell, '16, Middletown
 Harvey, D. F., Yale, '33, Hartford
 Harvey, E. R., Baltimore, '09, Seymour
 Harvey, J. LeR., Louisville U., '14, Waterbury
 Harvey, S. C., Ph.B., Yale, '07, Yale, '11, New Haven
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 Hatheway, C. M., Univ. & Bellevue, '03, Hartford
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 Hawthorne, J., Tulane, '20, Greenwich
 Haylett, H. B., Univ. Vt., '07, East Hartford
 Hazen, D. R., A.B., Amherst, '29, Harvard, '33, Hartford
 Hazen, R., B.A., Univ. Vt., '96, Univ. Vt., '98, Thomaston
 Heady, C. K., Jefferson, '13, Milford
 Heafey, J. R., Syracuse, '34, S. Norwalk
 Hebard, G. W., B.A., Williams, '32, Cornell, '36, New Canaan
 Heidger, L. C., Univ. Vt., '21, Stratford
 Heinemann, M., Goettingen, '25, New Haven
 Hendel, I., Jefferson, '17, New London
 Henderson, A. C., B.S., Amherst, '99, P. & S., N. Y., '03, Stamford
 Henderson, J., B.S., Smith, '26, P. & S., N. Y., '31, Stamford
 Hendricks, A. L., Yale, '07, New Haven
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 Hetzel, J. L., Yale, '26, Waterbury
 Heublein, G. W., Yale, '31, Yale, '34, Dr. Med. Sc., Pennsylvania, '39, Hartford
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 Heyer, H. H., U. City N. Y., '87, New London
 Heyman, J., Med. Coll. Va., '17, Hartford
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 Higgins, H. E., U. City N. Y., '96, Norwich
 Higgins, H. W., B.A., Middlebury, '27, Tufts, '32, Norwich
 Higgins, J. J., B.A., Georgetown, '24, Georgetown, '28, New Haven
 Higgins, W. L., U. City N. Y., '90, South Coventry
 Hill, E. S., McGill, '23, Torrington
 Hill, W. E., Bowdoin, '21, Naugatuck
 Hillman, M. M., Ph.B., Yale, P. & S., N. Y., '19, New Haven
 Hills, L. H., Wom. Med., Pa., '96, Willimantic
 Hinchey, R. J., Tufts, '21, Waterbury
 Hippolitus, J. D., B.S., Yale, '21, Yale, '25, New Haven
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 Hirata, I., Yale, '12, New Haven
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 Hirshberg, M. S., Tufts, '27, Hartford
 Hirshfeld, J. W., A.B., Cornell, '30, Cornell, '34, New Haven
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 Hodgson, T. C., M.B., Toronto U., '94, Trinity Med., '94, Berlin
 Hoffman, C. C., Buffalo U., '16, Hartford
 Hogan, W. L., B.A., Holy Cross, '14, M.A., Holy Cross, '24, Univ. Vt., '18, Hartford
 Holley, E., Albany Med., '96, Middletown
 Hollinshead, J. B., B.S., Hamilton, '33, Yale, '37, West Hartford
 Holt, K. R., B.S., Dartmouth, '23, Yale, '26, Hartford
 Holtz, R. S., Univ. Vt., '28, Hartford
 Hooper, G. H., Boston U., '29, Bridgeport
 Hopper, E. B., B.A., N. Y. U., '25, Yale, '29, Stamford
 Horn, B., B.S., Coll. City N. Y., '25, Univ. & Bellevue, '29, Bridgeport
 Horn, M. I., N. Y. Homeo., '15, Bridgeport
 Horning, B. G., M.S., Univ. Ore., '22, D.P.H., Johns Hopkins, '32, Harvard, '28, New York City (Hartford Co.)
 Horsefield, T. E., Univ. Vt., '29, Moodus
 Hough, P. T., B.S., Trinity, '26, McGill, '32, Hartford
 Houle, R. T., B.S., Villanova, '28, Georgetown, '32, East Hartford
 Howard, A. J., B.A., Yale, '17, Yale, '20, New Haven
 Howard, H. A., Tufts, '29, Wethersfield
 Howard, J. H., Georgetown, '18, Bridgeport
 Howard, L. A., B.S., Harvard, '31, Louisiana, '39, Danbury
 Howard, M. E., B.A., Columbia, '26, Johns Hopkins, '31, New Haven
 Howe, G. E., B.S., Mass. Agri. Coll., '13, Harvard, '18, Hartford
 Howlett, K. S., U. S. Naval Acad., '25, Vanderbilt, '31, Shelton
 Hubert, G. R., B.A., St. Bonaventure, '30, Yale, '35, Torrington
 Hudon, F. A., Penn., '34, Penn., '37, Bristol
 Hughson, D. T., B.A., Yale, '23, Yale, '27, Madison
 Hurlburt, E. G., Vt., '35, Bridgeport
 Hunkemier, E., N. Y. U., '33, South Norwalk
 Hurwitz, G. H., B.A., Harvard, '29, Univ. Md., '33, Hartford
 Hurwitz, H. M., Yale, '12, Hartford
 Hutchinson, J. E., B.A., Ohio State U., '09, Johns Hopkins, '14, Hartford
 Hutton, G. N., Univ. Toronto, '30, '32, '36, Hartford
 Hyde, C. E., Yale, '10, Bridgeport
 Hyde, C. J., Univ. & Bellevue, '03, Milford
 Hymovich, L., B.S., N. Y. U., '25, Jefferson, '29, U. Toronto, '32, Stamford
 Hynes, F. H., Tufts, '13, New Haven
 Ignace, S. J., A.B., M.A., Cath. Univ., '26, Georgetown, '30, New Milford
 Ingraham, A. E., Tufts, '00, Wethersfield
 Ireland, R. M., B.S., Vermont, Vermont, '31, New Milford (Fairfield Co.)
 Irving, J. G., A.B., U. Toronto, '29, U. Toronto, '32, Hartford
 Itzkowitz, H., B.S., Tufts, '30, Tufts, '34, New London
 Jack, G., Boston U. (Homeo.), '07, New Haven
 Jack, J. L., B.S., R. I. State, '15, Yale, '23, New Haven
 Jackson, A. F., B.S., Howard, '18, Howard, '22, Hartford
 Jackson, A. H., B. A., Princeton, '16, Yale, '24, Washington
 Jackson, A. J., P. & S., N. Y., '15, Waterbury
 Jackson, E. B., Johns Hopkins, '21, New Haven
 Jackson, E. J., Tufts, '19, Waterbury
 James, A. B., McGill, '27, Bridgeport
 James, L. P., B.A., Trinity, '24, Yale, '27, Hartford
 Jarvis, H. G., B.A., Yale, '06, Johns Hopkins, '10, Hartford
 Jenkins, C. A., Balt. Med., '11, Willimantic
 Jenkins, R. H., Med. Coll. Va., '16, New Haven
 Jennes, S. W., A.B., Yale, '30, Tufts, '34, Waterbury
 Jenovese, J. F., A.B., Pennsylvania, '27, Pennsylvania, '30, Hartford
 Johnson, A. A., P. & S., N. Y., '90, Waterbury
 Johnson, C. E., B.A., Stan., '22, Harvard, '26, New Haven
 Johnson, E. M., Yale, '14, New Haven
 Johnson, H. A., Univ. Vt., '25, Bangor, Maine (New Haven Co.)
 Johnston, E. H., Univ. Md., '00, Waterbury
 Jones, F. S., Yale, '28, B.S., Trinity, '24, Hartford
 Jordan, R. H., Virginia, '33, New Haven

- Joyce, W. M., Jefferson, '17, Middletown
 Kahn, E., Munich, '11, New Haven
 Kalett, J., Jefferson, '28, New Britain
 Kalin, J. I., B.A., Clark, '20, Harvard, '24, Hartford
 Kalman, E., Komensky, Czechoslovakia, '23, Bridgeport
 Kane, J. H., Md. Med., '04, Thomaston
 Kaprielian, H. K., Univ. Va., '08, Old Greenwich
 Kardys, J. A., Geo. Wash., '30, Hartford
 Karotkin, R. H., B.S., N. Y. U., '29, Univ. & Bellevue, '32, Hartford
 Kaschmann, J., Munich U., '22, Hartford
 Katz, D., Univ. Vt., '22, Univ. Vt., '25, Hartford
 Katz, H., B.A., Yale, '17, Harvard, '21, Hartford
 Katz, I., B.A., Clark, '31, N. Y. Med. Coll., '37, Meriden
 Kaufman, C., Jefferson, '19, New London
 Keating, J. J., B.S., Niagara, Bellevue, '34, New Milford (Fairfield Co.)
 Keddy, R. A., McGill, '24, Stamford
 Keefe, G. G., B.A., Holy Cross, '18, Univ. Md., '22, Hartford
 Keefe, R. S., B.A., Holy Cross, '20, Boston U., '25, Hartford
 Keefe, W. J., B.A., Holy Cross, '27, Univ. Md., '31, Hartford
 Keegan, D. F., B.A., Catholic Univ., Univ. Md., '21, Bridgeport
 Keeney, R. R., Jr., B.S., Trinity, '30, Tufts, '34, Manchester
 Keith, A. R., B.A., Colby, '97, Harvard, '03, Hartford
 Kelley, N. R., Harvard, '37, Rocky Hill
 Kellogg, H. K., B.S., Amherst, '89, P. & S., N. Y., '03, Norwalk
 Kelly, C. C., B.S., Davidson, '09, Johns Hopkins, '14, Hartford
 Kelly, J. F. C., Queen's, '28, Old Greenwich
 Kelly, J. F., Hartford
 Kelsey, W. M., B.S., Hamilton, '32, Johns Hopkins, '36, Westport
 Kendall, R. E., Johns Hopkins, '21, Hartford
 Kennard, M. A., Cornell, '30, New Haven
 Kennedy, C. S., B.S., Georgetown, '28, Georgetown, '30, Naugatuck
 Kennedy, R. E., B.A., Yale, '32, Yale, '36, Newtown
 Kennedy, W. C., Georgetown, '10, Torrington
 Kettle, R. H., Queen's Univ., '28, Norwich
 Kezel, A. P. C., B.S., Georgetown, '35, Stamford
 Keys, R. C., A.B., B.S., U. of Kansas, '27, Bridgeport
 Kilbourn, A., B.A., Yale, '21, B. S., Yale, '22, Yale, '23, Hartford
 Kilbourn, C. L., Yale, '97, New Haven
 Kilbourn, J. B., B.A., Trinity, P. & S., Balt., '11, Hartford
 Kilgus, J. F., Univ. Md., '31, Litchfield
 King, J. H., B.A., Yale, '82, P. & S., N. Y., '85, New Haven (Middlesex Co.)
 Kingsbury, I. W., B.A., Harvard, '96, P. & S., N. Y., '03, Hartford
 Kinney, K. K., B.S., Iowa Univ. Iowa, '21, Willimantic
 Kinsella, M. A., Tufts, '12, New Britain
 Kirschbaum, E. H., Yale, '12, Waterbury
 Klatskin, G., A.B., Cornell, '29, Cornell, '33, New Haven
 Klebanoff, H. E., B. A., Yale, Yale, '25, New Haven
 Kleiman, A. O., Tufts, '28, Tufts, '33, Hartford
 Klein, A. A., Louisville U., '29, Hartford
 Kleiner, S. B., Ph.B., Yale, '11, Yale, '15, New Haven
 Klinghoffer, K. A., B.A., N. Y. U., '27, M.A. Columbia, '28, Yale, '34, New Haven
 Klumpp, T. G., B.S., Princeton, '24, Harvard, '28, Chicago, Ill. (New Haven Co.)
 Knapp, C. S., B.A., Colgate, M.S., Colgate, P. & S., N. Y., '19, Greenwich
 Knapp, C. W., P. & S., N. Y., '12, Greenwich
 Knapp, R. P., P. & S., N. Y., '11, South Manchester
 Knauth, M. S., Columbia, '23, Wilton
 Kneale, H. B., B.A., DePauw Univ., '15, Johns Hopkins, '20, Bridgeport
 Knepp, J. W., Univ. of Richmond, Va., '05, Bridgeport
 Koffler, A., B.A., Duke, Jefferson, '34, Stamford
 Knowlton, D. J., B.A., Harvard, Harvard, '12, Greenwich
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 Koster, L. W., Ph.B., Brown, '33, N. Y. U., '37, West Haven
 Kott, J. H., A.B., Columbia, '30, Bellevue, '33, Torrington
 Koufman, W. B., B.S., William & Mary, '31, Tufts, '35, New Haven
 Kowalewski, V. A., B.A., Yale, '99, Yale, '02, West Haven
 Krinsky, C. N., Tufts, '33, New London
 Krosnick, M. Y., B.A., Yale, '26, Yale, '30, New Haven
 Kuh, C., B.A., Cornell, '14, Yale, '32, New Haven
 Kunkel, F. E., Yale, '26, Hartford
 Kushlan, S. D., Yale, '35, New Haven
 Laakso, A. O., B.S., Tufts, '33, Cornell, '37, Danielson
 La Bella, L. O., B.A., Wesleyan, P. & S., N. Y., '25, Middletown
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 Landry, B. B., B.A., Holy Cross, '16, Harvard, '20, Hartford
 Lang, W. P., Hahn, Phila., '01, North Haven
 Lankin, J. J., A.B., Williams, '33, Harvard, '37, Hartford
 LaPalme, J. A., Tufts, '25, Putnam
 LaPierre, A. J., Univ. Vt., '10, Norwich
 LaPume, A. A., B.A., Nicolet Sem., '18, Montreal U., '24, Bristol
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 Larimore, L. D., Wom. Med. Coll. of Penn., '15, Greenwich
 Larkin, C. L., B.A., Yale, '13, Yale, '15, Waterbury
 Larrabee, J. W., Harvard, '26, Hartford
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 Lawlor, M. J., Holy Cross, '02, P. & S., N. Y., '06, Waterbury
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 Leak, R. L., Albany Med., '98, Middletown
 Lear, M., Yale, '11, New Haven
 Leddy, P. A., Harvard, '24, New Haven
 Lee, F. N., B.S., Kansas, '21, Kansas, '23, Milford
 Lee, J. R., Queens, '24, Devon
 Lehman, E. B., Ph.B., Yale, '21, Univ. of Tennessee, '28, New Haven
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 Lekston, R. F., Med. Chi., Phila., '15, New Britain
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 Levy, A., B.A., Harvard, '25, Tufts, '31, Winsted
 Levy, D. F., Ph.B., Yale, '15, Yale, '19, New Haven
 Levy, M. N., Tufts, '23, Bridgeport
 Levy, N., B.S., Yale, '23, Yale, '27, Branford
 Levy, S. H., Tufts, '35, B.S., U. of Georgia, Stratford
 Levy, W., Yale, '11, Suffield
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 L'Heureux, J. A., B.A., Assumption, '30, Boston, '34, Meriden
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 Liebow, A. A., B.S., N. Y. C., '31, Yale, '35, Meriden
 Linde, J. I., Yale, '08, New Haven
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 Lirot, S. L. R., McGill, '32, Baltimore (New Haven Co.)
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 Little, H. C., Yale, '10, New Haven
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 Little, O. A. G., Boston Univ. School of Med., '35, Bridgeport

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 Loiacono, A. J., Ph.B., Brown, '23, Harvard, '27, New London
 Lombardi, P. F., Tufts, '21, Waterbury
 LoRusso, D. L., B.A., Cornell, '28, Marquette, '34, Torrington
 Loveland, E. K., Yale, '97, Watertown
 LoVetere, A. A., B.S., Tufts, '31, Tufts, '34, G. Washington, '35, Kensington
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 Lowsley, O. S., M.A., Stan., '05, Johns Hopkins, '12, New Canaan
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 Luby, T. J., McGill, '14, Hartford
 Luckner, W. G., B.A., M.A., Kentucky, '33-'34, Jefferson, '38, Stafford Springs
 Ludlow, G. C., Harvard, '15, Harvard, '19, New Canaan
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 Mathews, F. P., A. B., Harvard, '30, Southport
 Matteis, J. T., Yale, '26, New Britain
 Maurer, L. L., B.A., Beloit, '10, Yale, '16, New Haven
 Maxwell, J. A., B.A., St. Bonaventure, '10, Med. Coll. Va., '17, Bridgeport
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 McGaughey, J. D., Jefferson, '10, Wallingford
 McGourty, A. F., N. Y. Homeo., '18, Stamford
 McGourty, D. P., B.S., N. Y. U., '27, Jefferson, '27, Stamford
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 McIntosh, E. F., Yale, '97, New Haven
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 Nichols, R. W., Ph.B., Yale, '08, Johns Hopkins, '12, New Haven
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 Oberg, F. T., B.A., Clark, '12, Harvard, '16, Hartford
 O'Brasky, L., Jefferson, '22, New Haven
 O'Brien, F. J., Fordham, '17, Bridgeport
 O'Brien, J. F., Yale, '08, Waterford
 O'Brien, W. H. J., Ph.B., Yale, '08, Yale, '12, New Haven
 O'Connell, E. J., Holy Cross, '30, Tufts, '34, Unionville
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 O'Connell, M. F., B.A., Yale, '19, Yale, '22, Hartford
 O'Connell, P. H., Loyola, '29, Norwich
 O'Connell, W. M., Ph.B., Yale, Yale, '17, West Haven
 O'Connor, D. S., Bowdoin, '19, New Haven
 Oelschlegel, H. C., Jefferson, '11, Torrington
 Oeseau, H. T., Jefferson, '26, Stratford
 O'Flaherty, E. P., Cornell, '01, Hartford
 Ogden, A. W., Hahn, Chicago, '13, Norwich
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 Olmsted, J. G. M., C.M., McGill, McGill, '25, Hartford
 O'Loughlin, T. F., U. City N. Y., '96, Rockville
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 O'Meara, F. P., N. Y. M. C., '36, Glenbrook
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 Paine, R. C., Dartmouth, '00, Thompson
 Paladino, J. S., B.A., Colgate, '22, Boston U., '26, Hartford
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 Penner, S. L., Columbia, '34, Stratford
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 Perdue, R. E., Starling, '95, Norwalk
 Perakes, G. P., B.S., Georgetown, '31, Georgetown, '32, New Britain
 Perham, W. S., B.S., Mich., '28, Mich., '32, New Haven
 Perkins, C. W., Hahn, Phila., '01, Norwalk
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 Phillipson, S., N. Y., Homeo., '18, New Haven
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 Phillips, K. T., Tufts, '19, Putnam
 Phillips, P. L., Cornell, '30, A.B., Bowdoin, '24, Hartford
 Piasecki, J. L., Maryland, '12, Norwalk
 Piasta, P. F., Boston U., '24, Middletown
 Piazza, G. J., B.S., Fordham, '28, Boston U., '32, New Haven
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 Reid, L. R., Penna., '33, Shelton
 Reidy, D. D., B.A., Harvard, '23, P. & S., N. Y., '27, Hartford
 Reidy, M. J., P. & S., N. Y., '10, Winsted
 Reilly, F. H., Yale, '97, New Haven
 Reilly, W. J., Tufts, '35, Naugatuck
 Reiter, B. R., B.S., Princeton, '30, Harvard, '34, Bridgeport
 Renchan, J. M., Tufts, '28, Ansonia
 Rentsch, S. B., Univ. Mich., '23, Derby
 Resnik, E., B.A., Yale, '25, McGill, '30, New Britain
 Resnik, W. H., Ph.B., Yale, Johns Hopkins, '21, Stamford
 Resnisky, A. F., Georgetown, '23, Hartford
 Reynolds, H. St. C., Yale, '10, Hartford
 Reynolds, H. S., B.S., Union Coll., '11, Albany Med., '14, Hartford
 Reynolds, J. A., A.B., Holy Cross, '32, Tufts, '36, Waterbury
 Reynolds, R. G., B.S., Trinity, '22, Harvard, '26, Hartford
 Reynolds, W. M., A.B., Cornell, Columbia, '31, Greenwich
 Rihmer, H., B.S., Tufts, '34, Bridgeport
 Riccio, J. S., B.S., Fordham, '33, St. Louis, '37, Hamden
 Riccitelli, M. L., Ph.B., Yale, '19, Yale, '22, New Haven
 Richardson, R. A., Univ. Vt., '04, Bristol
 Ricksher, C., B.S., Parsons, '01, Johns Hopkins, '05, Middletown
 Rilance, A. B., McGill, '31, Shelton
 Rindge, M. P., P. & S., Cleveland '05 Madison
 Rindge, N. P., B.S., '32, Yale, '35, Clinton (Middlesex Co.)
 Riordan, M. D., Univ. Vt., '12, Willimantic
 Riordan, W. J., Univ. Md., '09, Wallingford
 Robbins, B. B., U. City N. Y., '94, Bristol
 Robbins, C. L., Yale, '29, New Haven
 Roberts, D. J., Univ. Vt., '16, Hartford
 Roberts, E. R., Med. Sch. Me., '13, Bridgeport
 Roberts, F. W., Johns Hopkins, '24, New Haven
 Robinson, A. J., Toronto U., '23, Hartford
 Robinson, W. J. T., L. I. Coll. Hosp., '21, Broad Brook
 Roccapriore, B. A., Jefferson, '31, Middletown
 Roch, G. E., B.A., Holy Cross, '30, Tufts, '34, Willimantic
 Roche, A. F., B.S., Georgetown, '15, Georgetown, '17, Hartford
 Roche, T. J., P. & S., Balt., '11, Bridgeport
 Rochlin, G. N., Maryland, '36, Newtown
 Rockwell, A. E., Johns Hopkins, '21, Bridgeport
 Rogers, F. P., Syracuse Univ., '33, West Hartford
 Rogers, O. F., Jr., B.A., Harvard, '08, Harvard, '12, New Haven
 Rogers, P. H., Yale, '12, West Haven
 Rogers, R. P., B.A., Harvard, '21, Harvard, '25, Greenwich
 Rogol, L., B.S., Yale, '29, L. I. Coll., '33, Danbury
 Rogol, O., Ph.B., Brown, '20, Dalhousie, '32, Seymour
 Rogowski, B. A., Ph.B., Yale, '20, New Haven
 Rollins, H. B., B.S., Dartmouth, '20, Yale, '22, Hartford
 Romaniello, R. J., B.A., Holy Cross, '23, P. & S., N. Y., '27, Hartford
 Rooney, J. F., Balt. Med., '03, Hartford
 Root, J. H., Ph.B., Harvard, '18, Waterbury
 Root, M. T., B.A., Cornell, '15, Cornell, '18, West Hartford
 Root, S. A., B.A., Barnard, '14, M.A., Columbia, '15, Cornell, '19, West Hartford
 Rosahn, P. D., A.B., Columbia, '24, N. Y. U., '28, New Britain
 Rose, S. A., N. Y. U. & Bell, '23, Stamford
 Rosenbaum, G. J., B.S., Trinity, '30, Tufts, '34, Hartford
 Rosenthal, E., Univ. of Wurtenberg & Munich, '24, Hartford
 Rosenthal, I., L. I. Coll., '10, South Norwalk
 Ross, A. M., Univ. of Basel, '35, Darien
 Roth, F. E., Univ. of Bellevue, '25, Hartford
 Rothblatt, R., Tufts, '32, A.B., Harvard, '37, Willimantic
 Rothschild, M. L., Ph.B., Yale, '19, Paris U., '26, New Haven
 Rowell, E. E., Hahneman, '99, Stamford
 Rowley, J. C., B.A., Harvard, '02, Harvard, '06, West Hartford
 Rowley, R. L., Yale, '03, Hartford
 Roy, J. L., B.A., Clark, '30, Tufts, '34, North Grosvenordale
 Rozen, A. A., B.A., Yale, '33, Yale, '37, New Haven
 Rubin, G. A., Edinburgh, '32, New Haven
 Ruby, M. H., Ph.B., Yale, '18, P. & S., N. Y., '21, Waterbury
 Ruby, R. J., Baylor, '36, Waterbury
 Russell, G. G., B.A., Harvard, Harvard, '19, Hartford
 Russell, J. J., N. Y. Homeo., '87, Putnam
 Russell, T. H., Ph.B., Yale, '06, Yale, '10, New Haven
 Russell, W. I., Yale, '09, New Haven
 Russman, C., Tufts, '23, Middletown
 Russo, J. D., Ph.B., Yale, '12, Yale, '16, New Haven

- Ryan, F. J., B.S., Trinity, '30, Tufts, '35, Hartford
 Ryder, R. H., P. & S., Balt., '13, Waterbury
 Ryder, W. H., Jefferson, '20, New Haven
 Ryley, R. N., B.S., Wesleyan, '30, Yale, '39, Mystic
 Rynard, W. M. W., Toronto U., '24, Stamford
 Sabloff, J., L. I. Coll. of Med., '34, New London
 Sadusk, J. F., Jr., B.A., Johns Hopkins, '31, Johns Hopkins, '35, New Haven
 Salinger, R., Johns Hopkins, '25, New Haven
 Salmond, P. H., Univ. Manitoba, '20, Richmond, Indiana (Fairfield Co.)
 Salvin, B. L., Geo. Wash., '21, Hartford
 Samponaro, N., B.S., Trinity, '25, Johns Hopkins, '29, Hartford
 Sanderson, R. V., Univ. Vt., '20, Winsted
 Sanduli, G. R., B.A., Harvard, '25, Tufts, '29, Waterbury
 Sanford, C. E., Yale, '06, New Haven
 Santoro, G. M., B.A., Cornell, '24, Waterbury
 Satti, C. J., Yale, '23, New London
 Savage, P. J., Maryland, '21, New London
 Savarese, M. R., L. I. College of Med., '11, New Haven
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 Sayers, J. J., B.S., Trinity, '30, Tufts, '35, Hartford
 Scafarello P. J., Tufts, '26, Hartford
 Scanlon, J. J., B.S., Georgetown, Georgetown, '35, Norwalk
 Scanlon, T. F., Yale, '07, Norwalk
 Scarbrough, M. McR., B.A., Univ. Oregon, '02, M.A., Yale, '05, Yale, '07, New Haven
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 Schaefer, J., Tufts, '17, Hartford
 Schechtman, C. T., Univ. Vt., '26, New Britain
 Schiavetti, A., B.A., Columbia, '26, Tufts, '30, Stafford Springs
 Schmidt, N. L., B.S., Yale, Vanderbilt, '27, Stamford
 Schneider, W., B.S., N. Y. U., '27, B.S. (Med.) Univ. Kan., '28, Geo. Wash., '30, Rockville
 Scholl, R. F., Yale, '12, New Haven
 Schuman, D. H., B.S., Columbia, '20, P. & S., N. Y., '22, Hartford
 Schupack, S. D., Tufts, '24, New Britain
 Schwartz, P. E., Tufts, '31, Portland
 Scott, C. R., B.S., Westminister, '15, Yale, '19, New Haven
 Scott, J. C., B.S., Haverford, '29, U. of Penn., '33, Essex
 Scott, W. J., Fordham, '16, Derby
 Scoville, D. H., Conn. U., '30, New London
 Scoville, W. B., B.A., Yale, '28, Pennsylvania, '32, Hartford
 Scudder, W. D., Harvard, '20, Hartford
 Scully, R. T., Fordham, '30, Georgetown, '35, New Britain
 Seabury, R. B., Harvard, '18, New Haven
 Sears, L., Harvard, '29, Norwich
 Segel, S., B.S., Vermont, '31, Vermont, '35, Norwich
 Segnalla, E., Yale, '12, New Haven
 Segur, G. C., P. & S., N. Y., '32, Hartford
 Seibert, A. F., Yale, '27, Hartford
 Sekerak, A. J., Univ. Md., '22, Bridgeport
 Sekerak, R. A., Maryland, '29, Bridgeport
 Sekerak, R. J., Maryland, '34, Bridgeport
 Selinger, J., Georgetown, '13, New Canaan
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 Sette, A. J., Geo. Wash., '27, Stamford
 Sewall, S., Maryland, '34, Maryland, '37, Elmwood
 Shafer, A., Univ., Pa., '18, Hartford
 Shaffer, T. E., Cornell, '29, Cornell, '32, New Haven
 Shaw, G. H., Syracuse U., '08, Hartford
 Shaw, L. E., Wom. Med. Coll. of Penn., '22, Greenwich
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 Shea, D. E., Loyola, '17, Hartford
 Shea, J. F., P. & S., Balt., '11, Bridgeport
 Shea, M. S., Univ., Vt., '21, New Haven
 Shea, R. E., Yale, '30, Willimantic
 Shea, R. O., P. & S., Balt., '14, Bridgeport
 Shea, V. T., Tufts, '31, Waterbury
 Sheahan, W. L., P. & S., Balt., '12, New Haven
 Sheehan, M. T., Yale, '10, Wallingford
 Shepard, W. G., Toronto U., '08, Hazardville
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 Sherer, H. C., U. City N. Y., '92, South Norwalk
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 Sherman, S. H., A.B., Dartmouth, '31, Columbia, '34, Stamford
 Sherwood, H., Univ. of New Hampshire, '32, N. Y. Med., '37, Durham
 Shirk, S. M., Hahn, Phila., '97, Stamford
 Shockley, F. M., Univ. Med. Coll. Kansas C., '13, Stamford
 Shulman, D. N., B.A., Johns Hopkins, '13, Johns Hopkins, '17, Hartford
 Shupis, A., Jr., Hahnemann, '38, Hartford
 Shure, A. L., Tufts, '27, New Haven
 Sigal, J. B., B.S., Trinity, '19, Yale, '23, Hartford
 Sigel, H., Tufts, '34, New Haven
 Siliciano, R. A., V., Hahn, Chicago, '24, Bristol
 Sills, T. H., B.S., Yale, '24, Yale, '27, Newington
 Silver, G. B., B.S., Trinity, '33, Tufts, '37, Long Island, N. Y. (Hartford Co.)
 Silverberg, S. J., P. & S., N. Y., '21, New Haven
 Simmons, E. M., B.A., Bowdoin, '19, Yale, '23, Southington
 Simon, L. G., B.S., N. Y. U., '24, N. Y. U., '27, South Norwalk
 Simonton, F. F., Med. Sch. Me., '03, Thompsonville
 Simses, J. P., Tufts, '37, Washington, D. C. (Fairfield Co.)
 Skiff, S. E., Hahn, Phila., '03, New Haven
 Skinner, C. E., LL.D., Rutherford, '01, Yale, '91, Darien (New Haven Co.)
 Slater, M., Ph.B., Yale, '19, Yale, '24, Hamden
 Slavin, J. E., Vermont, '12, Waterbury
 Slossberg, D. S., B.S., Trinity, '30, Tufts, '34, Hartford
 Slys, L. B., Boston U., '27, New Britain
 Smilgin, V. E., G. Wash. Univ., '38, New London
 Smith, A. C., P. & S., Balt., '10, Danbury
 Smith, C. S., B.A., Yale, '12, Hahn, Phila., '16, New Haven
 Smith, E. D., B.A., Yale, '96, Yale, '99, Bridgeport
 Smith, D. P., B.A., Yale, '10, Yale, '12, Meriden
 Smith, E. L., Yale, '96, Waterbury
 Smith, E. T., M.A., Trinity, '03, Hon., Yale, '97, West Hartford
 Smith, F., DeW., Hahn, Phila., '10, Guilford
 Smith, F. M., Univ., Vt., '11, Willimantic
 Smith, G. A., B.A., Yale, '03, Johns Hopkins, '07, Long Hill
 Smith, G. M., B.A., Yale, '01, P. & S., N. Y., '05, Pine Orchard, Branford
 Smith, G. M., Univ. Ill., '07, Hartford
 Smith, G. T., Yale, '08, Waterbury
 Smith, J. J., B.A., Columbia, '26, Univ. Md., '30, Bridgeport
 Smith, L. M., Fordham, '33, B.S., Tufts, '37, Stamford
 Smith, M. U., City N. Y., '83, New Haven
 Smith, N. N., Ph.B., Yale, '21, Yale, '24, New York City (New Haven Co.)
 Smith, S. M., Tufts, '20, Greens Farms
 Smith, S. R., B.A., Bucknell, '09, Med. Chi., Phila., '16, Bridgeport
 Smith, V. J., Univ. Pa., '20, New Britain
 Smith, W. B., Univ. Pa., '22, Wethersfield
 Smith, W. E., Univ. Mich., '10, Stamford
 Smith, W. F., Cornell, '34, Ph.B., Yale, '30, Hartford
 Smykowski, B. L., Balt., Med., '11, Bridgeport
 Snavey, M. E., B.A., Mt. Holyoke, Yale, '25, West Haven
 Snidman, G. I., Conn. State, '32, Virginia, '36, Hartford
 Snelling, P. W., B.A., Univ. Ga., '17, Harvard, '21, Hartford
 Snurkowski, C. V., Georgetown, '25, New Haven
 Sollosy, A., Tufts, '27, Bridgeport
 Solomon, C. I., B.S., C. City N. Y., '21, Yale, '25, Meriden
 Soltz, T., Jefferson, '11, New London
 Soreff, L., B.S., Tufts, '28, Tufts, '32, East Hampton
 Souther, S. P., B.A., Univ. Neb., '18, Johns Hopkins, '23, Hartford
 Spector, N., B.S., Tufts, Tufts, '24, Lynn, Mass. (Windham Co.)
 Speight, H. E., Georgetown, '27, Middletown
 Spekter, L., Trinity, '29, Univ. Roch., '33, Hartford
 Sperandeo, A., Ph.B., Yale, '21, Yale, '25, New Haven
 Sperry, F. N., Yale, '94, New Haven
 Spicer, E., Yale, '05, Waterbury
 Spignesi, J. T., B.S., Georgetown, '29, Georgetown, '30, Wallingford
 Spillane, B., B.A., Dartmouth, '13, Tufts, '16, Hartford
 Spinner, S., B.A., Tufts, '32, Tufts, '35, New Haven
 Sprague, C. H., P. & S., N. Y., '04, Bridgeport
 Squillacote, V. J., B.S., Trinity, '30, Univ. Rome (Italy), '34, New Britain
 Stahl, W. M., Univ. Md., '14, Danbury
 Standish, E. M., B.S., Wesleyan, '18, Harvard, '22, Hartford
 Standish, F. B., Yale, '03, New Haven

- Standish, H. C., Cornell, '28, West Hartford
 Standish, J. H., U. City N. Y., '95, Hartford
 Standish, W. A., B.A., Yale, '22, Yale, '25, Hartford
 Staneslow, J. S., B.A., Cornell, '22, Cornell, '26, Waterbury
 Starr, R. M., B.S., Mich. State, '17, Yale, '26, New London
 Starr, R. S., B.A., Trinity, '97, M.A., Trinity, '00, P. & S., N. Y., '01, Hartford
 Starrett, J. E., B.S., Univ. N. H., '26, Tufts, '30, Stamford
 Staub, J. H., L. I. Coll. Hosp., '99, Stamford
 Stein, A., Univ. Md., '17, Thompsonville
 Steincrohn, P. J., Univ. Md., '23, Hartford
 Steiner, W. R., B.A., Yale, '92, M.A., Yale, '95, L.H.D., Trinity, '31, Johns Hopkins, '98, Hartford
 Stempa, H., Berlin U., '98, Hartford
 Stephenson, C. W., Harvard, '22, Hartford
 Stetson, C. G., A.B., Cornell, '31, Cornell, '35, Milford
 Stetson, H. W., Univ. Vt., '06, Milford
 Stettbacher, H. J., B.S., Bates, '17, Harvard, '22, Waterbury
 Steudel, H., Univ. Kiel, '89, Ansonia
 Stevens, H. G., Maryland, '04, New Milford
 Stevens, M.A., Yale, '29, New Haven
 Stevenson, W. R., Boston U., '31, Bristol
 Stewart, H. E., Yale, '10, New Haven
 Stewart, L. Q., B.S., Middlebury, '26, Yale, '33, West Hartford
 Stietzel, E. E., B.S., Yale, '30, Columbia, '34, South Norwalk
 St. John, L. A., Fordham, '20, Hartford
 Stoddard, J. E., Boston, '04, Meriden
 Stolzheise, R. M., A.B., Willemette, '26, Univ. Oregon, '34, Hartford
 Stone, E. L., B.A., Williams, '16, Johns Hopkins, '20, New Haven
 Stone, H. R., Wesleyan, '99, Johns Hopkins, '04, Clinton
 Stone, M. J., B.S., Chicago, Rush, '22, Stamford
 Stone, W. S., P. & S., N. Y., '91, Norwalk
 Storms, W. F., Ph.B., Brown, '26, Harvard, '30, Wethersfield
 Storrs, E. R., Jefferson, '00, Hartford
 Storrs, R. W., B.S., Trinity, '17, Harvard, '20, Hartford
 Stoughton, D. H., McGill, '18, Hartford
 Strauss, M. J., B.A., Yale, '14, P. & S., N. Y., '17, New Haven
 Strayer, E. M., A.B., B.D., Baylor, '24, Columbia, '33, Bridgeport
 Strayer, L. M., Jr., B.A., Princeton, '26, Harvard, '30, Bridgeport
 Stretch, J. E., Geo. Wash., '28, Simsbury
 Strickland, H., McGill, '30, Meriden
 Stringfield, O. L., B.S., Wake Forest Coll., N.C., Univ. & Bellevue, '16, Stamford
 Strobel, J. E., Temple, '09, Waterford (Fairfield Co.)
 Stygar, J. S., B.S., St. Louis, '32, St. Louis, '33, Derby
 Sullivan, A. J., B.S., Catholic U., '22, Harvard, '27, Washington, D. C., (New Haven Co.)
 Sullivan, C. N., Mass., '26, McGill, '30, New Britain
 Sullivan, D., N. Y. U., '97, New London
 Sullivan, J. F., B.A., Yale, '90, P. & S., N. Y., '94, New Haven
 Sullivan, T. J., B.A., Yale, '15, Yale, '17, New Haven
 Sulman, M., P. & S., N. Y., '36, New London
 Sunderland, P. U., N. Y. Homeo., '94, Danbury
 Sunderland, W. A., M.E., Lehigh, Yale, '26, Danbury
 Sundquist, A. B., Tufts, '29, Tufts, '33, Manchester
 Suplicki, J. W., Tufts, '26, Norwich
 Sussler, D., Fordham, '16, Norwich
 Sutherland, F. A., B.A., W. & L., '22, Harvard, '26, Torrington
 Swan, H. C., Tufts, '03, Hartford
 Swarts, W. B., Pennsylvania, '34, Stamford
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 Swenson, A. C., Yale, '02, Waterbury
 Swett, P. P., Univ. & Bellevue, '04, Hartford
 Sword, B. C., N. Y. Homeo., '18, New Haven
 Tait, A. A., Carthage, '24, Univ. Ill., '27, Univ. Penn., '36, Univ. Ill., '30, West Hartford
 Talbot, H. P., Univ., Md., '27, Hartford
 Tanner, W. A., Univ. Vt., '12, Danielson
 Tarasovic, T. J., Tufts, '36, Bridgeport
 Tate, W. J., B.A., Trinity, '25, Yale, '29, Deep River
 Taylor, A., Rush, '29, Hartford
 Taylor, C. C., B.A., Dartmouth, Harvard, '16, Bridgeport
 Taylor, J. C., Univ. Mich., '91, New London
 Taylor, M. W., Tufts, '05, Hartford
 Taylor, R. M., B.A., Geo. Wash., '19, Geo. Wash., '22, East Haven
 Taylor, R. N., B.S., Yale, '26, Yale, '30, New London
 Taylor, S. P., Geo. Wash., '16, North Haven
 Teele, J. E., B.A., Tabor, '85, Wom. Med., Pa., '88, Greens Farms, (New Haven Co.)
 Tennant, R., B.S., Yale, '26, Yale, '29, New Haven
 Terhune, W. B., Tulane, '15, New Canaan
 TerKuille, R. C., U. of Roch., '32, Bridgeport
 Teuscher, W. P., A.B., Univ. Miami, Tufts, '32, Westport
 Thalberg, R. E., B.S., Yale, '23, Yale, '26, Southington
 Thayer, R. B., B.S., Bowdoin, '17, Bowdoin, '20, Somers
 Thencbe, C. L., Univ. Pa., '18, Hartford
 Thomas, J. J., Fordham, '21, Ansonia
 Thompson, C. G., N. Y. Homeo., '18, Norwich
 Thompson, H. G., B.A., Yale, '13, Harvard, '17, Hartford
 Thompson, K. W., A.B., Leland Stanford, '26, Harvard, '29, New Haven
 Thompson, L. E., Boston U., '25, Meriden, (New London Co.)
 Thompson, L. J., Univ. Mo., '19, Wash. U., '19, New Haven
 Thompson, S. A., B.A., Wes., '18, Cornell, '23, Greenwich
 Thoms, H., Yale, '10, New Haven
 Thomson, T. L., B.A., Princeton, '98, Hahn., Phila., '01, Torrington
 Thorne, L., Yale, '36, New Haven
 Throckmorton, V. J., S.B., Boston U., '30, Boston U., '33, Stamford
 Tiebout, H. M., Wesleyan, '17, Johns Hopkins, '21, Greenwich
 Tileston, W., Harvard, '95, Harvard, '99, New Haven
 Tinkess, D. E., McGill, '25, Greenwich
 Tirella, F. F., Tufts, '37, Bristol
 Tisher, P. W., Iowa Coll. of Med., '35, New Britain
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 Tokarczyk, J. J., Univ. Vt., '20, New Britain
 Tolk, N. R., Univ. & Bellevue, '20, Bridgeport
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 Tonken, L. C., Trinity, '30, Tufts, '34, Hartford
 Toole, F. E., B.A., Yale, '16, Yale, '19, New Haven
 Tortolani, A. P., A.B., Brown, '29, C. M., McGill, '34, Plainville
 Tovell, R. M., B.A., Queen's, '24, Queen's, '26, Hartford
 Tower, A. A., B.A., P. & S., N. Y., '19, Meriden
 Towne, N. A., Univ. Vt., '31, Naugatuck
 Townsend, W. C., B.S., Amherst, '20, Harvard, '25, Hartford
 Tracey, E. J., Ph.B., Yale, '20, Univ., Pa., '24, Norwalk
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 Tracy, R. G., Yale, '00, New Haven
 Trask, J. D., Ph.B., Yale, '13, Cornell, '17, New Haven
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 Troy, W. D., Jefferson, '36, Stamford
 Truex, E. H., Louisville U., '08, Hartford
 Tuch, M., Univ. & Bellevue, '06, Hartford
 Tukey, F. M., B.A., Bowdoin, '91, Harvard, '94, Bridgeport
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 Turton, E. H., Boston U., '00, Stamford
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 Twachtman, E., Virginia, '36, New Canaan
 Twaddle, P. H., Trinity, '31, Yale, '35, Hartford
 Tylec, L. L., Virginia, '35, Union City
 Tyler, M., B.A., Mt. Holyoke, '13, Johns Hopkins, '17, New Haven
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 Urquhart, R. G., McGill, '24, Norwich
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QUARTO NOTES (Continued from page 596)

ticularly to the general practitioner for whom it combines the useful portions of a number of textbooks that the internist or medical student must own for himself.

ARTIFICIAL PNEUMOTHORAX. *Its practical application in the treatment of pulmonary tuberculosis.* By Edward N. Packard, M.D., John N. Hayes, M.D., and Sidney F. Blanchet, M.D. Philadelphia: Lea and Febiger. 1940. 300 pp. 85 engravings. \$4.00.

Reviewed by PAUL S. PHELPS

The Trudeau Foundation brought together a group of contributors who under the leadership of an Editorial Committee presented this volume.

The Editorial Committee consisted of Edward N. Packard, John N. Hayes and Sidney F. Blanchet.

There were seventeen contributors to this volume, all Saranac Lake physicians. Among those mentioned are E. R. Baldwin, Leroy U. Gardner, Fred H. Heise, Edward N. Packard and Francis B. Trudeau.

As is stated in the foreword, this is not a compilation of the literature on the subject of artificial pneumothorax treatment but presents the results of individual experiences of the authors.

The volume, which consists of three hundred pages, is well illustrated with eighty-five engravings. There are nineteen chapters beginning with a brief historical review of artificial pneumothorax treatment and concluding with a chapter on "The Results of Treatment by Artificial Pneumothorax".

A group of men better qualified to write such a book would, to say the least, be difficult to find. Each chapter is written briefly, concisely and clearly. A long list of references is available at the end of each chapter.

In Chapter III, "Selection of Cases", the author indicates "artificial pneumothorax is often not a matter of deliberate choice; urgent hemoptysis, pregnancy, rupture of the lung or rapidly progressive disease, when the opposite lung needs consideration, demand wise judgment and quick action. The problem of choice does not rest entirely on a pathological foundation; social, economic and other factors must be taken into account."

"When this treatment is indicated *the earlier it is begun the better* because the patient's reserves have not become exhausted and his response to treatment will be quicker and surer."

Chapter VI, "The Technique of Operation", is well worth the time spent in reading. Although the technique of pneumothorax is a relatively simple procedure, artificial pneumothorax is fraught with danger of accident even when carefully performed by experienced hands. This is quite clearly illustrated in Chapter VII, "Accidents during Operation".

In Chapter VII the author makes the following statement when referring to the difficulties encountered in obtaining satisfactory collapse in the presence of adhesions. "Success may sometimes be gained by gradually increasing the pressures to +20 or +30 cm. of water and maintaining these high pressures by spacing the refills properly, but there is some danger in this method."

It is the feeling of the reviewer that only the most experienced physician in pneumothorax treatment should attempt any such pressures as are mentioned by the author. It is the opinion of many that if satisfactory collapse of the lung cannot be obtained by using only slightly positive or negative pressures that a supplementary or different form of treatment is indicated rather than attempting to produce the desired result by increasing the intrapleural pressure.

In Chapter X, "Complications of Artificial Pneumothorax", it is interesting to note the frequency of pleuropulmonary perforation, about four per cent according to the author and as high as ten per cent in one series of two hundred and thirty patients (Brown and Hayes). Although the author suggests, among other causes, low tension pneumothorax, it is interesting to speculate on what part the high tension pneumothorax plays in pleuropulmonary perforation!

In Chapter XI the author makes the interesting statement that empyema is a common complication of artificial pneumothorax and out of a series of 154 cases, 41.5% have died, one hundred and forty of the series having been followed from three to eight years.

The Problem of the Duration and Termination of Treatment is given careful consideration in Chapter XV. The value of a preliminary phrenic nerve operation is brought out.

This volume, in the opinion of the reviewer, should be part of the library of every physician doing artificial pneumothorax. The opinions and experience of such men as contributed to this work are worth reading.

THE PHARMACOLOGICAL BASIS OF THERAPEUTICS. By Louis Goodman, M.A., M.D., Assistant Professor of Pharmacology and Toxicology, Yale University School of Medicine, and Alfred Gilman, Ph.D., Assistant Professor of Pharmacology and Toxicology, Yale University School of Medicine. New York: Macmillan Company. 1941. 1383 pp. \$12.50.

Reviewed by SAMUEL DONNER

With the great strides that have been made in the science of pharmacology the art of therapeutics has gone a long way from the field of empiricism in which it had its origins. More and more the practitioner tends to restrict his prescriptions to drugs of scientifically proven therapeutic value. While the advent of rational therapy at first confined its disciples to a small group of drugs, scientific investigation is ever enlarging the armamentarium of the progressive physician.

This book is written with the object of presenting to medical students and the medical practitioners "rational drug therapy based upon a correlation of the pharmacodynamic action of drugs with the pathological physiology of disease". This objective it has most admirably achieved.

It opens with a review of the principles of pharmacology. Drugs are then grouped according to their therapeutic uses and in each instance the history of the drug or group of drugs, the chemistry, pharmacology and therapeutic uses are very completely discussed. A bibliography containing some of the more important references in the literature is appended to each chapter. The book closes with an appendix on prescription writing and at the end there is an excellent index. It contains information about a large number of subjects and is remarkably up to date, most of the newer drugs

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and vitamins being freely and adequately discussed. One wonders about the omission of a discussion of the snake venoms in so complete a volume.

The book reads easily and is a mine of useful information. It presents an unusual approach to pharmacology and will make a valuable and much used addition to the library of any physician.

THE THERAPEUTICS OF INTERNAL DISEASES
VOLUME III. Edited by George Blumer, M.A., M.D.,
Clinical Professor of Medicine, Yale University School of
Medicine. New York: D. Appleton-Century Co., Inc.
1941. 738 pp. \$10.00.

Reviewed by WILSON FITCH SMITH

A review of the third volume of Blumer's **THERAPEUTICS OF INTERNAL DISEASES** must necessarily result in a discussion of its ten chapters separately, particularly since each part is written by a different author who is a leading authority in his own field of medicine:—

1—*Diseases due to Fungi*, by David T. Smith, professor of bacteriology at Duke. This chapter contains a good, although simple, presentation of mycology, pathology, symptomatology and treatment. There are a number of helpful illustrations which add to the interest of the text.

2—*Metazoan Diseases*, by Ernest C. Faust, professor of parasitology at Tulane. Although the emphasis in this chapter is on treatment, and no attempt is made to give the details of diagnosis which are found in textbooks of parasitology, still a few pictures of the worms and ova concerned would have been welcome.

3—*Protozoan Diseases*, by Charles F. Craig, emeritus professor of tropical medicine at Tulane. This is a splendid chapter, chiefly on tropical medicine. Malaria is presented in considerable length with only one possible omission. No mention is made of the severe clinical picture frequently seen at Bellevue Hospital among the morphine addicts who take their drug intravenously ("main-line shooters") and who develop malaria from heavily contaminated communal syringes.

4—*Intoxications*, by George Blumer, clinical professor of medicine at Yale. Included in this chapter are poisonings by reptile and insect bites and by food poisonings.

5—*Diseases due to Physical Agents*, by Edgar A. Law-

rence, instructor in medicine at Cornell, and Harrison S. Martland, professor of forensic medicine at New York University. This chapter contains much of interest, particularly at a time of world-wide war. The effects of exposure to heat, cold and moisture are discussed, as well as the illnesses resulting from increased and decreased atmospheric pressures. Examples in modern aviation and submarine medicine are given. The part of this chapter devoted to asphyxiation and intracranial injuries contains many details of medico-legal interest.

6—*Treatment of Edema, Dehydration, Acidosis and Alkalosis*, by David M. Kydd, Mary Imogene Bassett Hospital, Cooperstown, N. Y. Pathological physiology is of primary importance in this chapter and it is clearly and concisely discussed.

7—*Pre- and Post-Operative Treatment, etc.*, by Monroe A. Melver, Mary Imogene Bassett Hospital. This chapter is of particular interest because of the increasing coöperation between the internist and the surgeon. It is up-to-date, including in its discussion vitamin K therapy in jaundice cases and the use of the Miller-Abbott tube in intestinal obstruction. The fluid balance theories of Collier and Maddock are well presented.

8—*Treatment of Diseases of the Lower Respiratory Tract*, by Donald S. King, assistant in medicine at Harvard and chief medical consultant at the Middlesex County Sanatorium. This is a 100 page text with excellent discussions and good diagrams. Pneumonia is omitted, being included in another volume.

9—*Treatment of Diseases of Blood and Lymph Vessels*, by Irving S. Wright, professor of clinical medicine at Columbia. This is a complete, critical and conservative presentation that cannot be improved upon.

10—*Treatment of Heart Disease and Heart Failure*, by H. M. Marvin, associate clinical professor of medicine at Yale. This is 130 pages of good sound principles. The newer potencies of digitalis preparations are mentioned. Particularly fine is the attitude against permanent invalidism after an attack of coronary thrombosis.

The volume as a whole contains a wealth of valuable information about the art and science of treating the various diseases discussed. This book, together with the two previously published volumes, constitute a veritable encyclopedia on the therapy of internal diseases and allied conditions.

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TEXTBOOK OF PEDIATRICS. (3rd edition, revised and reset.) By *J. P. Crozer Griffith, M.D., PH.D.*, Emeritus Professor of Pediatrics in the University of Pennsylvania; Consulting Physician to the Children's Hospital, Philadelphia; and *A. Graeme Mitchell, M.D.*, B. K. Rachford Professor of Pediatrics, College of Medicine, University of Cincinnati, Medical Director and Chief of Staff, Children's Hospital, Cincinnati. *Philadelphia: W. B. Saunders Company.* 1941. 991 pp. 220 illustrations. \$10.00.

Reviewed by **FREDERICK P. ROGERS.**

The first edition of this book appeared in 1933 under the title of *The Diseases of Infants and Children*. The second edition appeared in 1937 and the current edition under the new title appeared scarcely three months before the untimely death of its principle author, A. Graeme Mitchell. During this eight year period this book has been considered one of the few standard texts on pediatrics.

The new title was chosen "because we have emphasized even more than in previous editions the characteristics of good physical and mental health, the prevention of disease, and the modern knowledge of growth and development. Pediatrics, moreover, has come to denote that branch of medicine which treats of the child and his development and care, as well as of the diseases of early life and their treatment."

The previous editions were written from the experience of the authors. About this edition the authors make this statement. "The difficulty of reducing the great mass of medical knowledge to proportions which it is possible to include in the text book, and of separating facts from theory, analyzing the increasing number of medical publications, has led us to employ the procedure of first writing all of the material ourselves and then submitting much of it to those who had a right to be competently critical in one and another subject. In this manner we have secured many editors and critics of, and advisors for, our book rather than many individual authors." Sixty-four different authorities have been asked to contribute or criticize different sub-headings.

The book is divided into two divisions. Division one is eleven chapters and deals with general subjects such as physical growth and development, breast feeding, the therapeutics of childhood, characteristics of diseases in infancy and childhood, and so forth. Division two is devoted exclusively to diseases and is divided into twelve sections, each section dealing with specific diseases of organ systems.

The book is entirely up to date in treatment and includes the newer members of the sulfonamide group. The book is made very much more readable than the previous editions, due to the deletion of bibliography references which in the previous edition were numerical notations very frequently found following words, sentences, and paragraphs.

There need be no hesitancy in recommending this excellent work to students, pediatricians and general practitioners.

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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A TEXTBOOK OF OPHTHALMOLOGY. (2nd edition.)

By Sanford R. Gifford, M.A., M.D., F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School, Chicago; Attending Ophthalmologist, Passavant Memorial and Cook County Hospitals. Philadelphia: W. B. Saunders Company. 1941. 470 pp. 215 illustrations. \$4.00.

Reviewed by HENRY L. BIRGE, M.D.

This book covers the subject of modern ophthalmology in a precise manner. Emphasis has been placed on the important facts and no space has been wasted on interesting but unimportant details.

Among the 470 pages there are ample illustrations, charts and color plates. In this edition a section has been devoted to the correlation between retinal disease and cardiovascular renal disease, which is of interest to all practitioners who deal with vascular diseases.

There is helpful therapeutic advice on the newer drugs and vitamins used in ophthalmology, as well as occasional expression of personal experience and choice for the handling of general ocular diseases. There is finally a chapter treating with the eye as it relates to general diseases.

The book is recommended as a primary source of ophthalmic knowledge for all students, and its many fine points in

all branches of ophthalmology make it a worth while addition to any library, although it should be remembered that it is impossible to discuss many subjects to the extent of their importance in a volume this size.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. (19th edition.) By W. A. Newman Dorland, M.D., F.A.C.S., Lieut.-Colonel, M.R.C., U. S. Army. Philadelphia: W. B. Saunders Co. 1941. Revised and enlarged with 914 illustrations including 269 portraits. 1647 pp.

Reviewed by STANLEY B. WELD

For practical use neither the large unwieldy lexicon nor the abridged students' dictionary has the advantage that is found in this compact volume of convenient size. Like its predecessors this 19th edition is an improvement and contains more than 2000 new words from all departments of medicine and the related sciences.

There are many practical features found in this volume. Considerable collateral descriptive matter appears under the more important headings. Special prepared tables of Tests, Stains and Staining Methods, Methods of Treatment, etc., are included. The illustrations are often lacking in beauty but of value from a practical standpoint.

Table of Contents : September 1941

THE 1941 CLINICAL CONGRESS	Louis H. Nahum, M.D., New Haven	644
MATERNAL MORTALITY IN CONNECTICUT	Joseph H. Howard, M.D., Bridgeport	646
SOME REMARKS ON "CASES AND OBSERVATIONS; BY THE MEDICAL SOCIETY OF NEW HAVEN COUNTY"	George Blumer, M.D., New Haven	652
IONTOPHORESIS WITH ZINC PEROXIDE IN THE TREATMENT OF INDOLENT ULCERS	A. D. Gurewitsch, M.D., New York	664
DIAGNOSIS BY GASTROSCOPY	S. D. Kushlan, M.D., New Haven	665
NECESSITY FOR RECTO-SIGMOIDAL EXAMINATION	Simon B. Kleiner, M.D., New Haven	667
DISCUSSION OF SYMPOSIUM ON GASTRO-ENTEROLOGY	T. Grier Miller, M.D., Philadelphia	669
CONGENITAL UROLOGICAL ANOMALIES	C. H. Nueswanger, M.D., Waterbury	671
ACUTE ALEUKEMIC LEUKEMIA	James E. Crane, M.D., Stamford	673
TULAREMIA IN CONNECTICUT	Edward H. Gibbons, M.D., Newington	
Eugene L. Lamoureux, M.D., Hartford, and Henry A. Arkless, M.D., Newington		679
PSYCHIATRIC CONTRAINDICATIONS TO MARRIAGE	Eugen Kahn, M.D., New Haven	684
UNUSUAL CASE OF HODGKIN'S DISEASE	William Kinkelstein, M.D., Waterbury	687
THE NEW YALE LIBRARY	Herbert Thoms, M.D., New Haven	689

EDITORIAL

The Line Forms on the Left	692	The National Physicians Committee	
E. Kent Hubbard	693	in 1941	693

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	694	NEWS FROM COUNTY ASSOCIATIONS	709
CONNECTICUT HOSPITAL ASSOCIATION	697	NEWS FROM YALE UNIVERSITY SCHOOL	
MEDICAL PREPAREDNESS	700	OF MEDICINE	711
PUBLIC AFFAIRS	703	THE FORUM	711
INDUSTRIAL HEALTH	705	LETTERS TO THE EDITOR	713
OUR NEIGHBORS	709	QUARTO NOTES (Book Reviews)	714

MISCELLANEOUS

SEVENTEENTH CLINICAL CONGRESS		SPECIAL NOTICES	707
(List of Speakers, Program, etc.)	635	OFFICERS AND COMMITTEE CHAIRMEN	
		Connecticut State Medical Society	4
		Connecticut Hospital Association	4

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New Haven, Connecticut*

September 16, 17, 18, 1941

Attendance Record of
Connecticut Clinical Congress

YEAR	NUMBER	YEAR	NUMBER
(1925)	307	(1933)	246
(1926)	312	(1934)	644
(1927)	394	(1935)	624
(1928)	323	(1936)	633
(1929)	316	(1937)	694
(1930)	283	(1938)	598
(1931)	304	(1939)	581
(1932)	253	(1940)	700

The Connecticut State Medical Society

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1941 - 1942

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TO THE MEMBERS OF THE MEDICAL PROFESSION:

Time passes quickly, and the Seventeenth Clinical Congress of the Connecticut State Medical Society will soon be brought to your attention.

The program will have had the same intensive thought as to its character, to meet the needs of the general practitioner, and the specialty groups.

The speakers have been selected because they are leaders, and outstanding men of the medical profession, hence we can be assured on leaving the Congress that the time was well spent on this short intensive post-graduate course.

It is my privilege and pleasure to invite and urge you to attend the Seventeenth Clinical Congress.

JAMES DOUGLAS GOLD, M.D.



STANHOPE BAYNE-JONES, M.D.
Chairman
Clinical Congress Committee

1935 - 1941

A small, circular logo or mark, possibly a publisher's or printer's mark, located to the right of the caption. It contains some stylized, illegible text or a symbol.

The Connecticut State Medical Journal presents in the following pages the completed program for the 1941 Clinical Congress. As in previous meetings the high quality of the program is at once apparent. It is because of the intensive and serious attention that the program committee gives to their endeavor that the physicians of our section of the country have responded so well with their attendance. As evidence of this we would point out that during the 16 years in which these meetings have been held 1982 residents of Connecticut have registered. In addition to these there have been 459 registrants from outside of Connecticut; a total of 2441 registrants. Those coming from outside Connecticut have come from 16 States: California, Florida, Louisiana, Maine, Maryland, Massachusetts, Mississippi, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Virginia and the District of Columbia. Registrants from outside of the U. S. have included men from Canada, China, England, the Phillipine Islands, and Turkey. It is interesting to note that 1165 of all of these registrants at the Clinical Congress have returned and registered for more than one Congress. The list of guest and Connecticut speakers which will be found in this program follows:

IRVINE H. PAGE Indianapolis, Indiana
Director, Lilly Laboratory for Clinical Research,
Indianapolis City Hospital.

EMIL NOVAK Baltimore, Maryland
Associate Gynecologist, Johns Hopkins Hospital;
Chief of Staff, Bon Secours Hospital; Associate Pro-
fessor of Obstetrics, Univ. Maryland School of
Medicine.

JAMES L. POPPEN Boston, Mass.
Associate at Lahey Clinic, New England Deaconess
Hospital and New England Baptist Hospital (Neuro-
surgery).

GILBERT E. HAGGART Boston, Mass.
Chief of Bone and Joint Service, Lahey Clinic; At-
tending Orthopedic Surgeon, New England Baptist
Hospital and New England Deaconess Hospital.

ROBERT H. KENNEDY New York City
Surgical Director, Beekman Street Hospital; Associate Surgeon, New York Post-Graduate Hospital; Associate Clinical Professor of Surgery, Columbia University, College of Physicians and Surgeons.

E. JEFFERSON BROWDER Brooklyn, N. Y.
Consulting Neuro-Surgeon, Brooklyn State Hospital,
Bushwick Hospital, Kingston Avenue Hospital, Luth-
eran Hospital; Neuro-Surgeon, Beth Moses Hospital,
Brooklyn Hospital, Kings County Hospital; Surgeon,
Long Island College Hospital; Assistant Clinical Pro-
fessor of Surgery and Neurology, Long Island College
of Medicine.

Y. D. KOSKOFF
Chief of Neuro-Surgery and Associate in Department
of Neuro-Psychiatry, Montefiore Hospital.

GEORGE ST. J. PERROTT Bethesda, Maryland
Chief, Division of Public Health Methods, National
Institute of Health, United States Public Health Service;
Chairman, Health Division of the District of
Columbia Council of Social Agencies.

ERNEST P. BOAS New York City
Associate Physician, Mt. Sinai Hospital; Assistant
Clinical Professor of Medicine, Columbia University,
College of Physicians and Surgeons.

SAMUEL A. LEVINE Boston, Mass.
Senior Associate in Medicine, Peter Bent Brigham
Hospital; Consulting Cardiologist, Newton Hospital;
Assistant Professor of Medicine, Harvard Medical
School.

FRANK D. LATHROP
Boston, Mass.
Consulting Otolaryngologist, Corey Hill Hospital,
Massachusetts Women's Hospital, New England Baptist
Hospital, New England Deaconess Hospital and
Robert Breck Brigham Hospital.

BURRILL B. CROHN New York City
Consulting Gastro-Enterologist, St. Joseph's Hospital;
Associate Medical Gastro-Enterologist, Columbia
University Physicians and Surgeons.

FRANK H. LAHEY Boston, Mass.
Surgeon-in-Chief, New England Baptist Hospital and
New England Deaconess Hospital.

MATTHEW WALZER Brooklyn, N. Y.
Attending in Allergy, Jewish Hospital of Brooklyn.

JEROME P. WEBSTER New York City
Associate Attending Surgeon, Presbyterian Hospital;
Assistant Professor of Clinical Surgery, Columbia
University College of Physicians and Surgeons.

GRANTLEY W. TAYLOR Boston, Mass.
Instructor in Surgery, Harvard Medical School.

HARRY D. SONNENSCHN New York City
Attending Orthopedic Surgeon, Hospital for Joint
Diseases and Sydenham Hospital.

SARA M. JORDAN Boston, Mass.
Gastro-Enterologist, New England Baptist Hospital
and New England Deaconess Hospital.

HARRISON L. McLAUGHLIN New York City
Assistant Surgeon, Presbyterian Hospital.

PAUL A. YOUNGE Boston, Mass.
Assistant Visiting Surgeon, Free Hospital for Women;
Assistant in Gynecology, Harvard Medical School.

CONNECTICUT SPEAKERS

CHARLES L. LARKIN Waterbury
Attending Gynecologist, St. Mary's Hospital; Chief
of Obstetrics and Gynecology, Waterbury Hospital.

ARTHUR H. MORSE New Haven
Obstetrician- and Gynecologist-in-Chief, New Haven
Hospital; Professor of Obstetrics and Gynecology,
Yale School of Medicine.

JAMES R. MILLER Hartford
Consulting Gynecologist, Bristol Hospital and Char-
lotte Hungerford Hospital; Attending Obstetrician
and Gynecologist, Hartford Hospital.

DONALD A. BRISTOLL New Britain
Obstetrician and Gynecologist, New Britain Hospital.

JAMES B. HAMILTON New Haven
Assistant in Research Neurophysiology, Yale School
of Medicine.

HUGH WILSON New Haven
Chief of Radiology, New Haven Hospital; Associate
Professor of Radiology, Yale School of Medicine.

MILTON C. WINTERNITZ New Haven
Chief of Pathology, New Haven Hospital; Professor
of Pathology, Yale School of Medicine.

PETER STEINCROHN Hartford
Attending Physician, Hartford Municipal and Mt.
Sinai Hospitals.

JOHN R. PAUL New Haven
Associate Physician, New Haven Hospital; Professor
of Preventive Medicine, Yale School of Medicine.

DANIEL C. PATTERSON Bridgeport
Attending Surgeon, Bridgeport Hospital.

GUSTAF E. LINDSKOG New Haven
Associate Surgeon, New Haven Hospital; Assistant
Professor of Surgery, Yale School of Medicine.

VERA STEVENSON New Haven
Associate Psychiatrist, New Haven Hospital; Assist-
ant Professor of Psychiatry and Mental Hygiene, Yale
School of Medicine.

EUGEN KAHN New Haven
Psychiatrist-in-Chief, New Haven Hospital; Professor
of Psychiatry and Mental Hygiene, Yale School of
Medicine.

EDWIN F. GILDEA New Haven
Associate Psychiatrist, New Haven Hospital; Associ-
ate Professor of Psychiatry and Mental Hygiene, Yale
School of Medicine.

JOSEPH F. SADUSK, JR. New Haven
Associate Physician, New Haven Hospital; Instructor
in Medicine, Yale School of Medicine.

JAMES D. TRASK New Haven
Associate Pediatrician, New Haven Hospital; Associ-
ate Professor of Pediatrics, Yale School of Medicine.

FRANCIS G. BLAKE New Haven
Physician-in-Chief, New Haven Hospital; Dean and
Professor of Medicine, Yale School of Medicine.

HOWARD W. HAGGARD New Haven
Director of Laboratory of Applied Physiology; Pro-
fessor of Physiology, Yale University.

BERNARD S. BRODY New Haven
Assistant Attending Surgeon, New Haven Hospital;
Attending Neurological Surgeon and Attending
Neurologist and Psychiatrist, Grace Hospital; Assist-
ant Clinical Professor of Surgery, Yale School of
Medicine.

WILLIAM J. GERMAN New Haven
Associate Surgeon, New Haven Hospital; Associate
Professor of Surgery, Yale School of Medicine.

SAMUEL C. HARVEY New Haven
Surgeon-in-Chief, New Haven Hospital; Professor of
Surgery, Yale School of Medicine.

KENNETH THOMPSON New Haven
Associate Surgeon, New Haven Hospital; Assistant
Professor of Surgery, Yale School of Medicine.

PROGRAM

TUESDAY, SEPTEMBER 16

- 9:30 A. M. OSCAR F. COX, *Boston, Massachusetts*
Treatment and Nation-wide Control of Gonococcal Infections
- 10:00 A. M. PAUL A. YOUNGE, *Boston, Massachusetts*
Cancer of the Cervix
- 10:30 A. M. EMIL NOVAK, *Baltimore, Maryland*
Female Hormones in Clinical Medicine
- 11:00 A. M. CHARLES L. LARKIN, *Waterbury*
Urethritis in Women
- 11:10 A. M. ARTHUR H. MORSE, *New Haven*
Irregular Bleeding in Women Means Immediate Examination
- 11:20 A. M. JAMES R. MILLER, *Hartford*
Treatment of a Cystic Cervix by Cauterization
- 11:30 A. M. DONALD A. BRISTOLL, *New Britain*
Indications and Contraindications for Medical Induction of Labor
- 11:40 A. M. JAMES B. HAMILTON, *New Haven*
Male Hormone Substances: Their Effects and Limitations in Therapeutic Doses

12:00 — 2:00

LUNCHEON

Emil Novak, Speaker

- 2:00 P. M. HARRISON L. McLAUGHLIN, *New York City*
Treatment of Compound Fractures
- 2:30 P. M. JAMES L. POPPEN AND GILBERT E. HAGGART, *Boston, Massachusetts*
The Best Method of Examining a Back
- 3:00 P. M. ROBERT H. KENNEDY, *New York City*
Treatment of Fresh Wounds: Chemotherapy, Closed Plaster, etc.
- 3:30 P. M. E. JEFFERSON BROWDER, *Brooklyn, N. Y.*
The Immediate Treatment of Head Injuries
- 4:00 P. M. HUGH WILSON, *New Haven*
X-ray Demonstration—Craniospinal Injuries
Y. D. KOSKOFF, *Pittsburgh, Pennsylvania*
Demonstration of Essentials of a Neurological Examination for the General Practitioner
- 4:00 P. M. INSPECTION OF YALE MEDICAL LIBRARY
- 4:30 P. M. SPECIAL COURSE IN TRAUMATIC SURGERY

WEDNESDAY, SEPTEMBER 17

- 9:30 A. M. GEORGE ST. J. PERROTT, *Bethesda, Maryland*
Physical Defects in the General Population
- 10:00 A. M. IRVINE H. PAGE, *Indianapolis, Indiana*
Hypertension

- 10:30 A. M. MILTON C. WINTERITZ, *New Haven*
What is Arteriosclerosis
- 10:45 A. M. PETER STEINCROHN, *Hartford*
A New Diagnostic Sign in Myocardial Infarction
- 11:00 A. M. ERNST P. BOAS, *New York City*
Predisposing Factors in Myocardial Infarction
- 11:30 A. M. SAMUEL A. LEVINE, *Boston, Massachusetts*
Modern Treatment of Congestive Heart Failure

12:00 — 2:00

LUNCHEON

Ernst P. Boas, Samuel A. Levine, Irvine H. Page and Milton C. Winteritz, Speakers

- 2:00 P. M. FRANK D. LATHROP, *Boston, Massachusetts*
Recent Developments in the Treatment of Deafness
- 2:30 P. M. BURRILL B. CROHN, *New York City*
Diagnosis and Treatment of Bleeding from the Stomach
- 2:45 P. M. SARA JORDAN, *Boston, Massachusetts*
The Problem of Gastric Ulcer
- 3:00 P. M. JOHN R. PAUL, *New Haven*
Good and Bad Aspects of Gold Therapy in Arthritis
- 3:15 P. M. DANIEL C. PATTERSON, *Bridgeport*
The Value of X-ray Therapy in Post-operative Parotitis
- 3:25 P. M. GUSTAF E. LINDSKOG, *New Haven*
Bronchial Adenoma
- 3:40 P. M. VERA STEVENSON, *New Haven*
Office Treatment of Mild Depression
- 3:50 P. M. EUGEN KAHN AND EDWIN F. GILDEA, *New Haven*
How to Overcome the Smoking Habit
- 4:00 P. M. HUGH WILSON, *New Haven*
X-ray Demonstration—Heart Disease
SAMUEL A. LEVINE, *Boston, Massachusetts*
Demonstration of the Technic of Performing a Cardiac Examination
- 4:30 P. M. SPECIAL COURSE IN TRAUMATIC SURGERY

THURSDAY, SEPTEMBER 18

- 9:30 A. M. (Speaker to be announced)
Treatment of Virus Infections
- 10:00 A. M. JOSEPH F. SADUSK, JR., *New Haven*
New Sulphonamide Drugs and Their Uses
- 10:20 A. M. JAMES D. TRASK, *New Haven*
Streptococcal Fever, Scarlet Fever and Streptococcosis
- 10:40 A. M. FRANCIS G. BLAKE, *New Haven*
Vaccines for Influenza



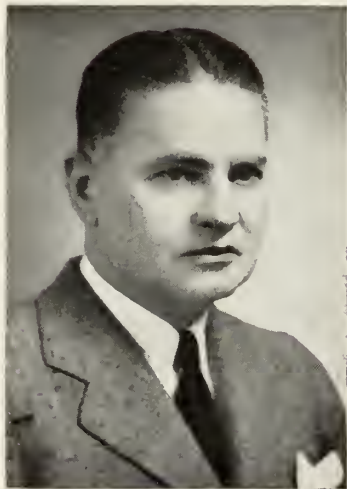
Emil Novak



James L. Poppen



Gilbert E. Haggart



Jefferson Browder



Yale David Koskoff



George St. J. Perrott

THURSDAY, SEPTEMBER 18 (*Continued*)

- 10:50 A. M. HOWARD W. HAGGARD, *New Haven*
Methods of Resuscitation
- 11:00 A. M. BERNARD S. BRODY, *New Haven*
Diagnosis and Treatment of Brain Abscess
- 11:15 A. M. WILLIAM J. GERMAN, *New Haven*
Management of a Patient with a Subarach-
noid Hemorrhage
- 11:30 A. M. FRANK H. LAHEY, *Boston, Massachusetts*
Estimation and Management of the Bad
Surgical Risk Case

12:00 — 2:00

LUNCHEON

Frank H. Lahey, Speaker

- 2:00 P. M. GRANTLEY W. TAYLOR, *Boston, Massachusetts*
Mouth Tumors
- 2:30 P. M. MATTHEW WALZER, *Brooklyn, N. Y.*
Gastro-intestinal Allergy
- 3:00 P. M. SAMUEL C. HARVEY, *New Haven*
Nutritional Deficiencies in Surgery
- 3:15 P. M. KENNETH THOMPSON, *New Haven*
The Care of the Feet in Arteriosclerosis
and Diabetes
- 3:30 P. M. JEROME P. WEBSTER, *New York City*
Modern Treatment of Burns
- 4:00 P. M. HARRY SONNENSCHNEIN, *New York City*
Demonstration on Foot and Ankle Problems
- 4:30 P. M. SPECIAL COURSE IN TRAUMATIC SURGERY

COURSE IN TRAUMATIC SURGERY

Afternoons at 4:30

September 16, 17, 18

New Haven Hospital

SAMUEL C. HARVEY, NEW HAVEN, AND OTHERS

- A. General Principles in the Treatment of Wounds
- B. Craniocerebral Injuries
- C. Spinal Injuries
- D. Injuries to the Chest
- E. Abdominal Injuries
- F. Injuries to the Kidneys and Urinary Apparatus
- G. Maxillofacial Injuries

H. Injuries to the Eye

I. Fractures

J. Injuries to Blood-vessels and Nerves

REGISTRATION FEE

The \$2.00 registration fee for this year's Clinical Congress will admit to all sessions of the Congress except the special course.

SPECIAL COURSE

On the opposite page will be found details of the course in Traumatic Surgery offered this year. Members of the Congress may register for this course on payment of an additional fee of \$1.00. Registration in this course will be limited as to the number of registrants. It is suggested that those who wish to avail themselves of the opportunity offered by this course register early.

LUNCHEONS

Luncheon will be served, at a moderate price, in the Law Buildings each day. At these luncheons, one of the guest speakers will address the Congress, in a question and answer session.

SECTION DINNERS AND MEETINGS

Section meetings are open to all members of the Congress. Arrangements for the section dinners are made by the individual sections.

WOMEN'S MEDICAL SOCIETY

The Women's Medical Society of Connecticut will hold its fall meeting at the time of the Clinical Congress. All women in medicine will be welcome.

PARKING AND TELEPHONE

Parking of automobiles for members of the Congress will be unrestricted as to time in the vicinity of the meeting place. Ask for parking sticker at the registration desk. Continuous telephone service will be maintained. Telephone 6-3663.

REGISTER EARLY

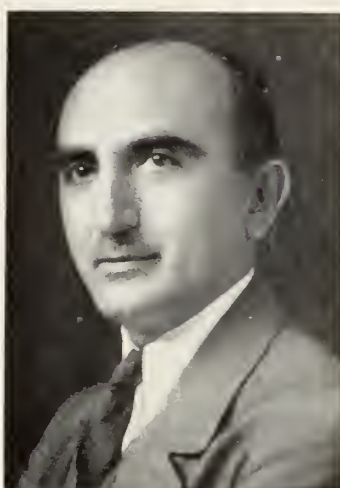
Early registration will facilitate the work of the committee and save time for you at the Congress. A registration blank which requires no postage has been placed in this announcement, for your convenience. If you expect to attend the Congress and have not already registered, fill out the form, enclose your check and mail it now.

INSPECTION OF THE YALE MEDICAL LIBRARY

Members of the Connecticut Clinical Congress are invited to inspect the New Yale Medical Library at 4:00 o'clock on Tuesday afternoon, September 16. In addition to the notable permanent collection, special exhibits of Connecticut memorabilia will be arranged anticipatory of the SEQUICENTENNIAL CELEBRATION OF THE CONNECTICUT MEDICAL SOCIETY. At five o'clock a reception by the Committee on the Clinical Congress for the members of the Society and their guests will be held in the Beaumont Room.



Irvine H. Page



Samuel A. Levine



Frank D. Lathrop



Burrill B. Crohn



Frank H. Lahey
President—A. M. A.



Grantley W. Taylor

THE 1941 CLINICAL CONGRESS

LOUIS H. NAHUM, M.D., *Chairman The Program Committee*

THE CLINICAL CONGRESS will this year show some important modifications from those of former years. Among these there may be mentioned the grouping of allied subject into one session, a further concentration on practical rather than theoretical aspects of medical practice, demonstrations which are designed chiefly from the practical point of view and the beginning of a special course on traumatic surgery which will continue weekly throughout the winter.

At first glance one is impressed with the importance of the speakers who are authorities in American Medicine. *Coxe* on gonorrhea, *Novak* on female endocrine diseases, *Kennedy* on the treatment of fresh wounds, *Browder* on cranial injuries, *Page*, *Winternitz*, *Boas*, *Lecine* on the aspects of cardiovascular diseases, *Crohn* and *Jordan* on peptic ulcer, *Kahn* on smoking, *Blake* and *Francis* on injuries. Other speakers include such names as *Lahey*, *Taylor*, *Walzer*, *Webster*. However, a more detailed perusal reveals that its design was not motivated alone by the desire to bring important men to address our membership, but more particularly to present individuals who would offer practical rather than theoretical consideration of their subjects. Throughout the session the emphasis will be on treatment and management: in other words, how to do things. Thus on the morning of the first day we have the treatment of gonorrhea, of cancer of the cervix, of female endocrine diseases, urethritis in women, irregular bleeding, and the induction of labor.

On the first afternoon a session of Orthopedics and Neurosurgical medicine, the treatment of compound fractures, how to examine a back, and how to treat fresh wounds and head injuries.

The morning of the second day finds the emphasis directed to cardiovascular diseases, the newer knowledge of arteriosclerosis, hypertension and myocardial infarction. The session ends with the treatment of heart failure.

The luncheon should present special stimulation because of the round table discussion which follows. Here the questions and answers embracing the whole field will be focused upon practical problems.

The afternoon of the second day brings a variety

of subjects to discussion. The newer treatment of deafness, causes and treatment of peptic ulcer, diagnosis and treatment of bleeding from the stomach, good and bad aspects of gold therapy in arthritis, the value of x-ray therapy in post-operative parotitis and bronchial adenoma, office treatment of mild depressive states, and how to overcome the smoking habit.

The morning of September 18 will be of special interest to pediatricians and surgeons as well as the general practitioner. The session will open with a talk on virus infections, following which will come an important summary of the present status of chemotherapy; then follows a talk bringing new light on scarlet fever and streptococcal infection. This will be followed by the value of vaccine in influenza and a discussion of methods of resuscitation. Following these talks will be considered the treatment of brain abscess and subarachnoid hemorrhage. One of the important addresses for this Congress will be presented by Doctor Frank Lahey who will bring to us the results of his extensive experience dealing with the problem of the bad surgical risk. During the luncheon Doctor Lahey will answer questions which promises to be a most interesting round table conference.

The last afternoon is also replete with important subjects: mouth tumors, gastro-intestinal allergy, nutritional deficiency in surgery, modern treatment of burns, management of the feet in arteriosclerosis and diabetes. The demonstrations at this time also will be of great practical importance: how to handle feet and ankle problems, the technique of performing a heart examination, how to do an adequate neurological examination, all of which will be presented by outstanding authorities in these fields. If one is more interested in roentgenology he may attend demonstrations in cranio-spinal injuries, or in heart disease.

One of the outstanding events of this Congress will be the visit to the new Yale Medical Library, a splendid structure housing the famous historical collections which are described in another article in this issue. This visit by our members will undoubtedly point out the importance of a great medical

(Continued on page 686)

*The Clinical Congress
of
The Connecticut State Medical Society*

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MATERNAL MORTALITY IN CONNECTICUT

An Analysis of Maternal Deaths During 1939

JOSEPH H. HOWARD, M.D., Bridgeport

The Author. B.S., 1916, M.D., 1918, *Georgetown University*. Attending Obstetrician, *St. Vincents Hospital, Bridgeport*. Chairman Committee on Public Health, *Conn. State Medical Society*

THE MATERNAL mortality rate in the United States has been high for several years and there has been little tendency toward a decline in this rate except in a few states. However, even with a reduction in a few states, the high rate in several southern states has kept the general mortality rate at a fairly constant level.

Connecticut is one of three states that boasts of a lower maternal death rate. This is due to:

1. Well equipped hospitals within easy reach of all.
2. Good roads for transportation of patients.
3. Strict supervision of obstetrical cases by the staff of most hospitals.
4. Close coöperation between obstetricians of the State.
5. An efficient State Health Department which coöperates with the Connecticut State Medical Society in analysing the maternal deaths.

During the past few years, with the aid of Social Security funds, it has been possible to initiate various activities for the purpose of further reducing our low mortality. Refresher courses were given in various parts of the state. These were not well attended and were finally discontinued, the Committee being of the opinion that this was not the type of education that the general practitioner desired.

A system of Obstetrical Consultants was established whereby in communities of less than fifty thousand population, an Obstetrical Consultant might be called and the charge for such services be paid from a special fund set up for this purpose. This latter service has been valuable in many instances but has not been used to the extent that it was intended.

The great value of the appropriation of Federal funds has been in the increase in field activities of the State Department of Health with the establish-

ment of greatly needed prenatal clinics and the education of the public in the recognition of proper prenatal care. The whole program has brought to the attention of the laity and especially of the medical profession the desirability of demanding and of giving improved obstetrical care.

METHOD OF STUDY

Upon the receipt by the Bureau of Vital Statistics of the State Department of Health of a death classified as maternal, a copy of this certificate is forwarded to the Chairman of the Public Health Committee of the Connecticut State Medical Society. This is mailed, together with a maternal mortality questionnaire, to a physician in the town where the death occurred with a request that he fill out the questionnaire after consulting with the physician who has signed the death certificate, and return it as promptly as possible. This method of collecting the data has caused considerable criticism. It has been the feeling the many physicians that the questionnaire should be sent directly to the physician credited with the death.

An outline of a case may demonstrate how such a procedure might afford erroneous information. The patient after delivery bled very freely and the uterus was packed. Bleeding continued and the patient was repacked. In spite of treatment, bleeding continued through this second packing and the patient died in less than two hours from the time of delivery. The certificate was signed "Pulmonary Embolus," and yet from a study of the questionnaire we would place this death in the post-partum hemorrhage group.

Coöperation is necessary if we are to gather correct data which may be of aid in reducing our mortality. It is not in the spirit of criticism that we request this information. Perfect obstetrical judgment does not exist. In so many cases, on the completion of a delivery, one looks back and realizes that some other method of delivery might have resulted in a more favorable outcome, but at the onset of labor the plan of delivery seemed to be the one of choice. One cannot foresee many complications that may arise during the process of labor.

During 1939 there were 23,106 deliveries in the

State of Connecticut. Of this group 61 mothers died, a mortality rate of 2.6 per thousand live births. All of these deaths occurred in hospitals, eleven cases being delivered at home or the place of delivery was not stated, and were removed to the hospital after delivery and death occurred there. All cases were delivered by physicians. The number of midwife deliveries has decreased to a very small fraction of the total.

It will be noted that the largest group consisted of Puerperal Hemorrhage and Other Accidents of Child Birth, the latter consisting of pulmonary embolus, acute cardiac dilatation with vasomotor collapse, paralytic ileus, etc.

The second largest group comprised the toxemias. It is here that we have an opportunity of reducing our rates by prenatal care and proper selection of the type of delivery.

Analyzing the puerperal deaths according to period of gestation again brings out the high rate of hemorrhage and toxemia at term. Under twenty-seven weeks, sepsis leads, but here we have the septic abortions which account for most of the cases. In most instances these septic abortions are admitted on a general surgical service, or in larger hospitals on the gynecological service, are never seen by the obstetrician but are credited as obstetrical deaths.

A study of the deaths according to age of the mother shows a high rate in cases over thirty years of age. This is due apparently to two factors:

1. The risk of abnormal pregnancies and deliveries with repeated pregnancies at close intervals.
2. The tendency to neglect prenatal care because previous pregnancies have been uneventful.

The rate in cases over thirty years of age is so striking, it would seem that this is a weak spot that can be overcome by lay education. This point is emphasized in the next chart dealing with prenatal care and parity of the mother.

Again we see the high death rate in cases of eight and ten pregnancies. In the group of eight pregnancies with three deaths, two of these patients had no prenatal care and one had inadequate care. In those cases having ten or more pregnancies, there were four deaths, one of whom had adequate prenatal care, one no care, and two unknown, but the probabilities are they had none.

Space does not permit a detailed description of adequate, inadequate, indifferent and poor prenatal care and so the classification as used here is merely

TABLE No. 1

In grouping our maternal deaths we have used the "Daily" classification.

PUERPERAL CAUSES OF DEATH—DOCTOR DAILY CLASSIFICATION

CAUSE OF DEATH	NUMBER
I. <i>Abortion and Ectopic Gestation</i> - - -	8
140—Abortion with septic condition	7
141—Abortion without mention of sepsis	0
142—Ectopic Gestation	1
II. <i>Puerperal Hemorrhage and other Accidents of Childbirth</i> - - - - -	26
144—Puerperal Hemorrhage	16
149—Other Accidents of Childbirth	10
III. <i>Puerperal Septicemia and Puerperal Phlegmasia, Alba Dolens, etc.</i> - - - - -	7
145—Puerperal Septicemia (not specified as due to abortions)	4
148—Puerperal Phlegmasia, Alba Dolens, and Sudden Death	3
IV. <i>Toxemias</i> - - - - -	18
146—Puerperal Albuminuria	13
147—Other Toxemias	5
V. <i>Other Accidents of Pregnancy</i> - - -	2
143—Other Accidents	0
150—Other Conditions	2

TABLE No. 2

PUERPERAL CAUSES OF DEATH¹ BY PERIOD OF GESTATION
CONNECTICUT, 1939

CAUSE OF DEATH ¹	PERIOD OF GESTATION				
	TOTAL	UNDER 28 WKS.	28-37 WKS.	NOT TERM	REPORTED
Total	61	14	15	30	2
Hemorrhage—ante partum	6	1	3	2	....
Hemorrhage p.o. or shock	14	1	2	11	....
Sepsis ²	16	7	1	8	....
Toxemia	17	4	8	5	....
Other Causes and Accidents	6	1	1	4	....
Not reported	2	....	....	....	2

¹Classified according to the interview.

²Includes 5 cases of pulmonary embolism all at term.

TABLE No. 3

MATERNAL DEATH RATES¹ BY AGE OF MOTHER,
CONNECTICUT, 1939

AGE OF MOTHER	NUMBER	RATE ¹
Total	61	2.6
Under 20	2	1.5
20-29	20	1.5
30-39	35	5.1
40 and over	4	5.7

¹Rates are based on 1,000 live births in each age group.

TABLE No. 4
MATERNAL DEATH RATES ACCORDING TO PRE-NATAL CARE AND PARITY OF MOTHER

					DEATHS		PRENATAL CARE						
NUMBER OF PREGNANCY					NO.	RATE ¹	ADEQUATE	NOT ADEQUATE	NO CARE	NOT REPORTED			
Total					-	-	-	61	2.6	23	17	11	10
1	-	-	-	-	23	2.4	13	6	3	1			
2	-	-	-	-	10	1.6	6	1	2	1			
3	-	-	-	-	6	1.9	3	2	1	0			
4	-	-	-	-	2	1.3	0	1	0	1			
5	-	-	-	-	2	2.3	0	1	1	0			
6	-	-	-	-	2	3.5	0	2	0	0			
7	-	-	-	-	3	8.7	0	2	1	0			
8	-	-	-	-	3	13.7	0	1	2	0			
9	-	-	-	-	1	7.3	0	1	0	0			
10 and over	-	-	-	-	4	14.8	1	0	1	2			
Not reported	-	-	-	-	5	....	0	0	0	5			

¹Rates are based on 1,000 live births in each age group.

TABLE No. 5
PRENATAL CARE¹ RECEIVED BY WOMEN DYING FROM PUERPERAL CAUSES CLASSIFIED BY CAUSE OF DEATH AS DETERMINED BY INTERVIEW

CAUSE OF DEATH	TOTAL	ADEQUATE	NOT ADEQUATE	NO CARE	NOT REPORTED
Total—All causes	61	23	17	11	10
Hemorrhage and shock	20	9	7	3	1
Ectopic preg. with hemorrhage	1	....	....	1	....
Placenta praev. permature sep.	9	4	4	1	....
Postpartum hemorrhage	9	4	3	1	1
Shock following del. within 10 hrs.	1	1	....	....	....
Infection and Sepsis	16	5	3	4	4
Abortion with sepsis	6	1	1	4	....
Ectopic pregnancy with sepsis	1	....	....	....	1
Puerperal sepsis	3	1	1	....	1
Pulmonary embolism	5	3	....	....	2
Infections other than puerperal	1	....	1	....	....
Toxemias	17	7	4	3	3
Hyperemesis gravidarum	2	1	....	....	1
Preeclamptic or eclamptic	8	3	2	1	2
Nephritis	5	2	1	2	....
Pyelo-nephritis	1	....	1	....	....
Other toxemias	1	1	....	....	....
Other Causes and Accidents	6	2	3	1	....
Cardiac	3	1	1	1	....
Caesarean Section	2	....	2	....	....
Vasomotor Collapse—Shock	1	1	....	....	....
Not reported	2	....	....	....	2

¹Prenatal care in this study shall have the following meaning:

Adequate—Patient consulted a physician within the 1st trimester of gestation—complete medical examination—regular monthly follow-up visits with regular urine analysis, blood pressure and weighing at each visit.

Not Adequate—Receiving some prenatal care but less than above.

No Care—Received no prenatal care until period of confinement.

TABLE No. 6

CAUSE OF DEATH¹ OF WOMEN DYING FROM PUERPERAL CAUSES ACCORDING TO PRINCIPAL TYPE OF OPERATION FOR DELIVERY

PRINCIPAL OPERATIVE	TOTAL	ANTEPARTUM HEMORRHAGE	POSTPARTUM HEMORRHAGE	TOXEMIA	SEPSIS ²	OTHER CAUSES AND ACCIDENTS	NOT REPORTED
Total - -	61	7	13	17	16	6	2
Caesarean - -	16	2	2	6	2	4	....
Forceps—Low - -	8	2	2	2	2	....	....
Forceps—Medium - -	3	....	2	....	1	....	....
Forceps—High ³ - -	1	....	....	1	....	....	....
Version - - -	5	2	2	....	....	1	....
Hysterotomy - -	2	....	....	2	....	....	....
Ectopic - - -	1	1	....	....	....	....	....
Dilatation and Curettage	2	....	1	....	1	....	....
Breech - - -	1	....	1	....	....	....	....
Self Induced Abortion	5	....	....	....	5	....	....
No Operation - -	15	....	3	6	5	1	....
Not reported - -	2	....	....	....	....	....	2

¹Classified according to interview.²Include 5 cases pulmonary embolism.³Followed by version.

Note—25% of cases following forceps were due to sepsis.

adequate, not adequate, and no care. Every physician is acquainted with adequate prenatal care, but it is indifference that sometimes causes him to neglect an examination of the urine, recording of blood pressure, weight and complete physical examination, together with instructions to the patient in the hygiene of pregnancy and the necessity of periodic visits to the physician's office for monthly or semi-monthly examination. Not all the fault in the matter can be placed at the door of the physician. A study of our cases shows that the blame is on the patient, especially in that large group of multigravida over thirty-five years of age. In the State of Connecticut there are twelve towns having maternity hospitals with no prenatal clinics. These towns have an average population of 12,169 and average 250 deliveries a year.

Table No. 5 brings out in detail the causes of death in relation to prenatal care. Here we note that of fifty nine cases in which all details are available, only twenty three could be considered as having had adequate care, and of these, four died before they reached the seventh month of gestation. The inadequacy of prenatal care is, moreover, well shown in the toxemic group where only seven among seventeen women had adequate care.

In Table No. 6 are classified the deaths according to type of delivery. Here we note that toxemias again lead with seventeen deaths, six of which fol-

lowed Caesarean and six in which there was no operation, the remaining five occurring after forceps or hysterotomy. The important point, as brought out by this table, is the question of Caesarean in toxemia, especially in the more severe degrees of toxemia in which operative delivery carries so high a mortality.

There were two deaths following dilatation and curettage. One from uncontrollable hemorrhage, and a second from sepsis following a curettage with an unrecognized ectopic pregnancy.

A cross section of the Caesarean deaths is here given to show the indications, length of labor, condition of membranes, etc. A comment by the attending obstetrician is given as to the patient's condition before operation and the amount of prenatal care. Unfortunately, we did not include in the survey the type of Caesarean, which might have been of value in the few infected cases.

The danger of repeated vaginal examinations is well recognized. It is interesting to note a rather low percentage of vaginal examinations in the cases reported.

Although repeated vaginal examinations carry great risk, we also know that sepsis can and does occur without vaginal examination. We have seen the occasional case of intercourse just prior to labor cause sepsis. We see at times cases septic during the months of January and February when respiratory

TABLE No. 7
CLASSIFICATION OF CESAREAN SECTIONS—1939

CASE NO.	INDICATION OF OPERATIVE	LENGTH OF LABOR	MEMBRANE RUPTURED	AGE	NUMBER OF PREGNANCY	COMMENT	PRE-NATAL CARE
4	4 Previous Cesarean Sections	?	?	34	7	Moderate p. operative hemorrhage	N-A
6	2 Previous Cesarean Sections	None	Not Ruptured	31	3	Nephritic pressure rose from 180/124 to 230/140	Adeq
8	Uterine inertia, borderline pelvis	3 days	Ruptured 23 hours	25	1	Paralytic ileus p. operative	N-A
9	Cesarean section 11 months previous	None	Not Ruptured	29	2	Abruptio placenta in prior pregnancy	Adeq
16	Central placenta praevia	None	Not Ruptured	31	1	Died 10 days after delivery—sepsis	Adeq
21	Abruptio placenta—rigid cervix	None	Not Ruptured	26	3	Patient admitted in shock	N-A
29	Placenta Praevia	None	Not Ruptured	34	6	Profuse hemorrhage before delivery	N-A
32	Patient unconscious—B.P. 230/140	1 hr.	Ruptured 6 hours	38	1	Shock on admission	N-A
35	No dilation—advised by Consultant	3 days	Not Ruptured	32	1	Post-op. hemorrhage	N-A
39	Head disengaged—cephalo-pelvic disprop	15 hrs.	Ruptured 1½	30	2	1st baby difficult operative	N-A
42	Eclampsia	None	Not Ruptured	39	4		N-A
45	Disproportion	10 hrs.	Ruptured 3 hours	30	1	No pre-natal care	None
53	Pressure rising—Albumin 4 plus toxemia	None	?	31	1		Adeq
55	Ruptured uterus—hemorrhage	None	Not Ruptured	39	9	Previous Section 2 years Shock—died 4 min. post. op.	N-A
56	Nephritic—failure to take up cervix	18	Not Ruptured	37	2	Spinal Anesthesia—No Pre-natal care	None
60	Contracted pelvis posterior head	6	Not Ruptured	29	1	Pulmonary embolism—lived 19 days	Adeq

¹Under pre-natal care—Adeq.—Adequate
N-A—Not Adequate
None—No care

infections are prevalent and we have seen spontaneous deliveries become septic when no explanation was possible. However, the determination of the progress of labor is best judged by rectal examination and abdominal palpation, and, if sepsis occurs, one does not feel that one has in any way contributed toward it.

In larger hospitals with well established maternity departments, it has become a rule that all cases that have been in labor over a designated time must be seen by one of the attending obstetricians. In the rural areas this service is rendered by an obstetrician on the Consulting List with no extra expense to the patient.

Table 9 shows the time at which consultation was called. In almost half the cases a consultant was called in before death, or no consultation was requested. There is a growing tendency among the younger men in general practice to call a consultant early, and further education in this respect will help

materially in avoiding the more dangerous complications of labor.

COMMENT

If Connecticut is to maintain her enviable position as one of the few states with a low maternal mortality rate, the physicians of the State must keep this problem continually before them. Obstetrical judgment is only acquired by long experience in a vast number of cases. Few men have perfect obstetrical judgment. However, when occasions arise where the opinion of another might aid, there are available at all times obstetricians of experience who are willing to offer a helping hand. We physicians cannot be content in stopping with adequate delivery care, but, realizing how many of these cases of toxemia might have been saved, each one of us must take it upon himself to educate the laity to the value of proper prenatal care. The establishment of more Prenatal clinics in those towns now lacking in this service and the follow-up of all cases is essential.

In spite of the fact that 100% of the maternal deaths occurred in hospitals during 1939, the hospital is the best place for delivery. Emergencies such as placenta praevia and postpartum hemorrhage can not be adequately and safely treated at home, since before transportation can be provided or the patient has reached the delivery table death is so apt to occur.

A review of the deaths during 1939 calls for no condemnation of the physicians of Connecticut. If one could foresee what would happen in certain cases one might approach the problem in a different manner, but one does not always expect these complications.

May I ask the coöperation of every physician in the State in this matter of maternal mortality study. Be assured that it is not to criticize that we seek this data, but merely to see more clearly loopholes in our prenatal and obstetrical care with the object of maintaining our low maternal mortality rate.

I wish to express my thanks to Doctors Clifford and O'Malley for their invaluable aid in this study and to Mr. Tracy for his help in compiling the statistics.

TABLE No. 8
NUMBER OF WOMEN DYING FROM PUERPERAL CAUSES REPORTED TO HAVE HAD VAGINAL EXAMINAIONS WITHIN 48 HOURS OF DELIVERY BY PRINCIPAL TYPE OF OPERATION FOR DELIVERY

PRINCIPAL OPERATIVE	TOTAL	VAGINAL EXAMINATION		
		YES	NO	NOT REPORTED
Total	61	19	35	7
Caesarean Section	16	4	11	1
Forceps--Low	8	4	4	....
Forceps--Medium	3	1	2	....
Forceps--High	1	1	....	....
Version	5	1	4	....
Hysterotomy	2	1	1	....
Ectopic	1	1	....	....
Dilatation and Curettage	2	....	1	1
Breech	1	....	1	....
Self Induced Abortion	5	1	4	....
No Operation	15	5	7	3
Not reported	2	....	....	2

TABLE No. 9
TIME AT WHICH CONSULTATION WAS CALLED FOR WOMEN DYING FROM PUERPERAL CAUSES ACCORDING TO PERIOD OF GESTATION

PERIOD OF GESTATION	TIME CONSULTATION CALLED					NOT REPORTED
	TOTAL	BEFORE LABOR	DURING LABOR	BEFORE DEATH	NONE	
Total	61	20	11	15	9	6
Under 28 Weeks	14	6	....	6	....	2
28--37 Weeks	15	10	....	2	2	1
Term	30	4	11	7	7	1
Not reported	2	....	....	....	....	2

Changes in Clinical Thermometer Specifications

The specifications for marking clinical thermometers which are sold in Connecticut has been changed. The word "SEAL" in the CONN. SEAL marking has been eliminated. Manufacturers are now authorized to mark their thermometers with the abbreviation CONN. followed by a designating letter which has been assigned to each manufacturer.

In order to allow manufacturers to dispose of stock which have already been engraved in the old manner, a grace period will be allowed during which both type of engraving will be satisfactory. Thermometers engraved in the old manner with a CONN. SEAL will be accepted as legal until January 1, 1942. Thermometers engraved according to the new specifications will also be acceptable during the remainder of 1941. However, after January 1, 1942, all clinical thermometers must be engraved according to the new specifications to be legal for sale in Connecticut.

The abbreviation CONN. and the designating letter may be engraved either in block letters or in script.

Conn. Health Bull., May 1941.

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SOME REMARKS ON "CASES AND OBSERVATIONS; BY THE MEDICAL SOCIETY OF NEW HAVEN COUNTY"

GEORGE BLUMER, M.D., *New Haven, Conn.*

F. R. Packard, in an article on "American Medical Societies Founded before 1787," gives the practitioners of New Haven County the credit of founding the ninth medical society of the United States, and both Packard and J. S. Billings, Sr., state that the society published the first volume of medical transactions issued in this country.¹ It is to this volume that I wish to call attention.

At the meeting of the Medical Society of New Haven County held Jan. 2, 1788 the following action is recorded:

"Voted, That a Collection of the most interesting Cases that have been communicated to the Society, be made & that they be published in a pamphlet at the expense of the Society."

"Voted, That Messrs. Leverett Hubbard, Eneas Munson, Ebenr Beardsley Samuel Nesbitt & Samuel Darling be a Committee for the above purpose."

Again, at the meeting of the Society held April 2, 1788 the following votes are on record:

"Voted, That a subscription be opened by the members of this Society for the purpose of carrying into effect a Vote of this Society, at their last annual Meeting on the first Wednesday of January last, To publish in a Pamphlet at the expense of this Society a collection of the most interesting Cases & that the Money arising from this Subscription be lodged with the Treasurer to the Order of the Committee of Revision & Publication so far as the expense of Paper and printing authorise, the remainder if any to remain with the Treasurer as a fund for the use & benefit of said Society—and that the Amount of the sale of the Pamphlets be applied by the Treasurer to the credit of said Society's funds."

"Voted, That the aforesaid Committee be authorised to annex a suitable Divise to the Pamphlet proposed to be Published."²

It is probable that the committee went to work immediately after the April meeting, for the first record of sale of the pamphlets is to be found in a memorandum on the penultimate page of the minute book in the hand of Samuel Darling which indicates that some seventeen copies were disposed of to members and subscribers at the meeting held July 2, 1788. This memorandum, and one on the opposite page showing payments to Mr. Meigs, the printer, in October, 1788, are somewhat conflicting. The receipt of forty-seven copies in three lots is noted on one page and the sale of 122 copies on the same page. Most of these copies were distributed in single numbers, but twelve copies were sold to Isaac Beers, six to a Mr. Green and fifty to Mr. Robert Hodge of Boston. I can find nothing in the minutes to support Bronson's statement that 500 copies were printed. The original price seems to have been one shilling and eightpence, but Doctor Spalding is recorded as buying a copy in 1791 for one shilling and sixpence. There is no record as to whether the society sold the books at a profit. Mr. Meigs is credited

Reprinted from the Bulletin of the Society of Medical History of Chicago, April, 1921, Vol. II, pp. 205-218. Read before the Beaumont Medical Club, New Haven, Nov. 14, 1920.

1. The full title is "Cases and Observations; by the Medical Society of New Haven County, in the State of Connecticut, Instituted in the year 1784. New Haven: Printed by J. Meigs, 1788."
2. The punctuation and capitalization of these votes follow the original of the Secretary and Treasurer, Samuel Darling.

with receiving at various times amounts totaling five pounds three shillings, which would pay for exactly sixty-eight volumes at one and sixpence, but if 122 pamphlets were issued he only received tenpence apiece. The whole question of the disposition of the pamphlets and the financial transactions connected therewith seem to have been on the minds of the society's members, for on three occasions either the original committee or a specially appointed one was requested "to examine the state of the publication made by the society and report at the next meeting." A careful scrutiny of the minutes fails to disclose any such report.

DESCRIPTION OF THE PAMPHLET

The pamphlet is in octavo form and contains a preface of three pages, a table of contents and the twenty-six cases and observations.

On the title page there is, in addition to the printed matter, a device, doubtless the one authorized in the vote of April 2, 1788, in the form of a male head in profile. The cranium is adorned with what appears to be a fluted cap tied behind with a ribbon, and the chin is garnished with voluminous whiskers which might be described in modern parlance as modified "Galway sluggers." Beneath the head is the motto "Plus Ultra." While the head does not exactly correspond to known busts of any of the fathers of medicine I feel confident that it is a representation of the head of Asklepios taken from an ancient Greek coin. Several similar heads have been found among pictures of old coins.³ What appears to be a cap is undoubtedly formalized hair, the strings being the ends of the fillet which the ancients so often wore. The arrangement of the beard is unusual, as the type of head used to represent either Zeus or Asklepios nearly always has a curly beard which is not separated from the moustache. However, I have found a statement to the effect that occasionally in such representations the beard is formalized and separated from the moustache. I had hoped to find in the Yale Library the original from which the device was made but have been unable to do so. Either Samuel Darling or Josiah Meigs, the printer,⁴ both of them classical scholars, may have possessed some book on ancient coins, or may have copied the design from some old medical book. It seems probable that the woodcut on the title page, and also the illustration in the text, were engraved by Amos Doolittle, who was perhaps the only engraver in New Haven at the time capable of doing the work. Mr. Hopson thinks that Tisdale, who worked with Doolittle, probably did not do the cuts. The motto "Plus Ultra," while originally that of the Royal Arms of Spain, is commonly used elsewhere. It is not clear just why it was selected in this case.

3. I am greatly indebted for help in clearing up the origin of the device to Mr. Albert C. Bates, Professor Baur, Mr. W. F. Hopson, Mr. George Dudley Seymour, Lieut.-Col. F. H. Garrison, and the Staff of the Yale Library.

4. Josiah Meigs was no ordinary printer. He graduated at Yale in 1778, was a classical scholar and fond of mathematics. He was City Clerk of New Haven for many years and at one time practiced law in Bermuda. He gave up printing to become Professor of Mathematics and Natural Philosophy in Yale College, became President of the University of Georgia a few years later, and finally moved to Washington, D. C., where he became Surveyor General of the United States and later Commissioner of the General Land Office.

CASES AND OBSERVATIONS;

BY THE

MEDICAL SOCIETY

OF NEW HAVEN COUNTY, IN THE

STATE OF CONNECTICUT,

Instituted in the Year 1784.



New-Haven : Printed by J. Meigs, 1788.

PREFACE OF THE PANIPHLET

The preface sets forth the laudable ambitions of the "infant institution" in language so choice and so redolent of the times that I cannot forbear quoting a part of it:

"All attempts to improve a science which is subservient to the dearest interests of humanity, must meet the approbation of every benevolent mind. Attempts of this nature are particularly necessary, and must be peculiarly useful, in an infant empire, where the seeds of science, though widely disseminated, are but just beginning to germinate. Their future growth and increase depend on the care and attention with which they are nurtured. To excite others to this laudable and salutary work, is one principal object of this publication. It has not, we presume, proceeded from incapacity, or a criminal inattention to the interests of humanity that the faculty in this country have hitherto contributed so little to the general stock of Medical knowledge. In a widely extended country, at a distance from each other, it has not been in their power to unite their efforts in this noble pursuit. The late war brought many ingenious and learned Physicians together from all parts of the continent, and the army formed them into a temporary society, whose unreserved communications have contributed to the improvement of medical knowledge, and the establishment of a new and important area in the healing art. By this means the faculty have become more sensible of the importance of uniting their endeavours, and several Medical societies have been formed in different parts of the United States. Should similar institutions become general, and permanent, there is reason to hope that Medical literature will soon be in as flourishing a state in this country as in any part of Europe. A spirit of emulation will take place, sloth and ignorance decline, and the art appear with dignity and lustre. Should this effort of the society contribute in the smallest degree to effect those desirable ends, it will afford them ample satisfaction for their labour."

It is not clear whether the committee as a whole was responsible for the preface, as it is unsigned. It is perhaps fair to assume that Samuel Darling, the secretary, was chiefly responsible, as he was doubtless elected to his office partly because of his literary attainments. He was a Yale graduate of 1769 who served a year as Rector of the Hopkins Grammar School. It may be added that in his later years he was chiefly engaged as a druggist who bled and pulled teeth, his toothache "avenger" being preserved to this day among the collections of the New Haven Colony Historical Society. Bronson says that he was worthy, conscientious and truthful.

ARTICLES IN THE PANIPHLET

The table of contents of the pamphlet contains the titles of twenty-six articles contributed by nine members of the New Haven County Medical Society and one outsider, Doctor Benjamin Gale, of Killingworth. Of these twenty-six articles seven were contributed by Doctor Samuel Nesbitt, six by Doctor Ebenezer Beardsley, four by Doctor John Spalding, two each by Doctors Leverett Hubbard and Eneas Munson, and one each by Doctors Elnathan Beach, Abraham Tomlinson, Hezekiah Beardsley, Levi Ives and Benjamin Gale.

DOCTOR SAMUEL NESBITT

Coming now to the meat of the pamphlet we may consider first the contributions of Doctor Samuel Nesbitt. This worthy gentleman, a temporary backslider from the field of medicine into the then still closely allied profession of the ministry, is stated to have been a Scotsman who probably received his medical training at Edinburgh. He practiced in New Haven some ten or twelve years, and may be briefly characterized as the Doctor Sangrado of

the local profession. His practice was never extensive, but his acquaintance with European faculties is said to have done much to spread the fame of the New Haven County Medical Society into foreign lands.

Certain of his cases are worthy of attention as evidence of two traits of his professional character: his strong adherence to and faith in the so-called "antiphlogistic" treatment and his boldness and skill as a surgeon.

Throughout his writings there is abundant evidence that he was dominated, one might almost say obsessed, by the importance of blood-letting, purging and puking. The therapeutic imprint of the seventeenth century was strong upon him, though others of his time, notably Benjamin Rush, were similarly afflicted. In the case of Capt. Trowbridge's negro servant, Polydore, who suffered from "a singultus from an adhesion of the liver to the diaphragm," he let blood frequently and prescribed mercurials "to be worked off with salts and manna." In the case of Joseph Kent, supposedly suffering from the effects of drinking cold water but probably the victim of an overdistended stomach with rupture of a peptic ulcer and subphrenic or hepatic abscess, he "let blood copiously" and repeated the process "often and occasionally," but as he himself acknowledges, "without any permanent relief." In the case of Josiah Tuttle, a young man "of large frame and rigid fibres" who suffered from varioloid, he bled the patient some fifty ounces and also gave him tartar emetic. He ascribes the mild eruption to his treatment, evidently being unaware of the fact that there is frequently no relationship between the severity of onset and the extent of the skin lesion in smallpox. His *magnum opus* from an antiphlogistic standpoint was Capt. Noble Hinnan, a gentleman of forty, who had the good fortune to be "of a very plethoric habit." The worthy Captain was suddenly seized with "a copious discharge of blood from the stomach" which recurred and was followed by a not inconsiderable loss of blood from the bowels. At the outset of his illness Doctor Nesbitt found him "languid and sensibly affected with the loss of blood." "Notwithstanding," says he, "I immediately bled him to the quantity of sixteen ounces," and after two hours, the vomiting of blood returning ("to the quantity of about two pounds by estimation") he again let blood to the amount of twelve ounces. Without going into the details of this sanguinary orgy we may summarize this aspect of the case by noting that between early morning of Nov. 13, 1773 and late afternoon of November 14 the plethoric Captain lost one hundred and sixty ounces of blood from spontaneous bleeding and ninety-two ounces through the ministrations of Doctor Nesbitt, in all two hundred and fifty-two ounces. As Nesbitt naively but truthfully says, "The treatment, by God's blessing, had the desired effect." It speaks well for the eighteenth century constitution that the Captain was at work again three weeks after the original attack of hematemesis.

The one case which shows Doctor Nesbitt's surgical daring, and which resulted in securing him a widespread surgical reputation, was that of Stephen Hotchkiss, aged ten, whose tendo Achillis was accidentally severed by the stroke of a drawing knife. Contrary to all the tenets of the day Doctor Nesbitt made an incision parallel to the divided tendon, secured the retracted

end, and sutured the tendon. The result was an excellent one notwithstanding the fact that the wound became infected with the usual copious discharge of "laudable" pus. Nesbitt's description of the apparatus used to keep the severed ends in apposition shows common sense and ingenuity and is worthy of quotation:

"The apparatus made use of to restrain the limb in a state of flexure, and its muscles from any unfavorable action, were a strong piece of pasteboard, accommodated to the upper part of the foot or instep and ankle, and confined by bandage, which by pressure against the anterior and inferior part of the leg, prevented the elevation of the foot; the leg was preserved in a state of flexure, and the gastrocnemii muscle in a state of constant relaxation, by a strap affixed to the heel of a slipper, that went over all the bandages on the foot, and led to a bandage above the knee, with a buckle to lengthen or shorten it at pleasure."

EBENEZER BEARDSLEY

Next to Doctor Samuel Nesbitt in the number of his contributions to the pamphlet stands Doctor Ebenezer Beardsley. He was born of respectable parentage in Stratfield, now Bridgeport, in 1746 and died in 1791 "of a rapid and sudden consumption or *tuberculosis pulmonalis*." He practised first in Waterbury, served three years as surgeon's mate in the Revolutionary War and moved to New Haven in 1779. His brothers, Gershom of Mansfield and Hezekiah of New Haven, were, like himself, both druggists and physicians. Ebenezer Beardsley is said to have had poor health and a delicate constitution but in spite of this he accomplished much. He was one of the most popular physicians in New Haven and was well known outside the city. In addition to conducting a successful practice he became one of the largest importers of drugs and medicines in the United States.

His six case reports are clearly written and show careful observation. Even though his interpretation of the findings is at times of necessity faulty, it is always possible to recognize the disease from his description. In his case of enteritis, which was really an intestinal obstruction from intussusception, he gives a good clinical description of the appearance of a patient with acute abdominal disease. He says "his pulse was extremely quick, small and unequal; his countenance pale and sunk, his respiration quick and laborious, and he was so restless that it was with difficulty that his attendants kept him in bed; his thirst was great but he almost instantly threw up whatever was given him." In commenting on his case he well shows the temper of his mind. The patient, it may be noted, had vomited six round worms at the onset of his illness, which circumstance Beardsley, after the autopsy, believed to have nothing to do with the cause of death. Indeed, he says that the worms "being disturbed by the increased heat and disagreeableness of their situation, quitted it in search of a better." In connection with this phase of the case Beardsley severely criticises certain authors "who are too apt to consider all diseases of the intestines in children, as arising from worms." "Allen," he says, "advises the practitioner in treating the diseases of children, if he meets with any symptoms he cannot readily account for, to place it to the account of worms." "But," says Beardsley, "this advice was certainly unbecoming a philosopher and physician." "It is much more safe and honourable to imitate the example of the illustrious Boerhaave, who assures us that

he made it an invariable rule, never to quit the bedside of his patient, until he had fully ascertained the state and condition of all the important viscera." Of Beardsley's other case reports the "Hydrocephalus Internus," which was probably tuberculous meningitis, the "scirrhus tumor of the pylorus," the "fatal peripneumony" and the "case of enlarged Gall Bladder" all show the same careful observation and clinical sense but are otherwise not especially worthy of comment.

His sixth communication is an account of an epidemic of dysentery which broke out in the 22nd regiment of the Continental Army while it was quartered in New York City. One hundred men of this regiment were taken ill with dysentery within a week, the associated regiments entirely escaping, as did also the inhabitants of the city. Beardsley's study of the situation shows his clear mind and his sound common sense. He noted that only certain companies were affected and that these men were quartered either in garrets or cellars, while the rest of the troops had moved into tents some twelve days previous to the outbreak. He noted that the men were overcrowded and that they speedily recovered when moved into airy quarters; and he drew the conclusion that the disease originated from "the confined and putrid atmosphere which these unfortunate men lived in." I will quote the last paragraph of this report as it is not without interest:

"From the foregoing history the following practical deductions may be made: First, that *caeteris paribus*, people who live in airy, capacious houses, are less liable to be seized with dysenteries and other putrid fevers, than those who live in smaller houses and breathe a more confined air. Secondly, that patients labouring under these diseases instead of being confined in small, tight rooms (the common and fatal practice of the country in general), ought either not to be confined to the house at all, or to be placed in the most spacious and airy rooms. Thirdly, that it is highly probable that smothering feather beds, warm, close rooms, and overcareful nursing, are among the principal causes of the fatality which too often attend this class of diseases. Fourthly, that persons in the latter stages of a pulmonary consumption, when they usually spit large quantities of purulent matter, and their perspiration and other excreta are of a putrid disposition, ought to be treated in this respect as tho' they were sick with a dysentery or other putrid fever; which will not only conduce to their preservation and comfort, but is the only means of safety to their attendants and friends."

JOHN SPALDING

Doctor John Spalding, who contributed four observations to the pamphlet, was born in 1739 and died in 1813. He practiced in Windham County before the Revolution, was surgeon to the 3rd regiment commanded by Israel Putnam during the Revolutionary War, and came to New Haven about 1781. He was the popular New Haven surgeon of his day but his reputation with the public was much greater than with the profession. It is said that his skill was not at all equal to his reputation, that his judgment was not always good and that he was too fond of cutting. Judging from a remark of President Stiles, he apparently suffered from alopecia universalis and always wore a sorrel or golden colored wig. Gossip had it that he lost his hair through his wife attempting to poison him with arsenic.

The first case he reports is that of a fracture of the parietal bone which he treated by trephining and removal of the fragments. The patient, a boy of 7, finally recovered in spite of infection of the wound. The case illustrates

the toleration of children to serious head injuries rather than any great skill on Doctor Spalding's part. His case of amputation of the leg for a divided artery also shows the ill effects of infection and was merely a case of delayed hemorrhage of a type well known in the period preceding antiseptic surgery. His case of cut throat is interesting but in no way extraordinary.

The one report which gives evidence that Doctor Spalding possessed some skill and ingenuity is that of Mr. Ezra Curtis, who was injured by the bursting of a musket, the breech pin of which was driven through the orbit and lodged between the vertebral column and the outer angle of the lower jaw. The breech pin was not suspected to be in the wound and was not discovered until six months later when an abscess formed about it which was opened. The patient applied to Spalding for removal of the breech pin which could not be dislodged by main force. Spalding finally removed it by making a trephine opening through the inferior maxilla which permitted some loosening of the pin. It was then sawed or filed across after repeated sessions and removed "to the inexpressible joy of the patient." The jaw, which had been stiff, returned to normal and the patient recovered completely except for the loss of his eye.

ENEAS MUNSON

Eneas Munson, the son of a respectable mechanic, was born in 1734 and died in 1826. He was educated for the ministry but gave it up for medicine because of dyspepsia and hypochondriasis from too close application to study. He graduated at Yale in 1753, taught school in Northampton, practiced medicine two years in Bedford, N. Y., and then moved to New Haven where he practiced 66 years. He had a peculiar talent for wit but rarely laughed.

He contributed two articles to the pamphlet. The first, entitled a "Case of Lock'd Jaw, successfully treated by electricity" was obviously, from his excellent description, not tetanus but a case of major hysteria of traumatic origin. Munson himself noted that her fits were "very similar to hysteric fits" and he also notes that electricity "most instantaneously relaxed the spasms, to the astonishment of every bystander."

His second case was the choleric Mr. Caleb Hotchkiss, who died of consumption of the lungs, evidently of the fibroid type, as he had suffered from active symptoms for 15 years. On two occasions during attacks of hemoptysis he expectorated calculi which were the occasion of the report. Finally, after expectorating a calculus on September 9, "he continued gradually to decay, until the latter end of December following, when welcome death closed the scene." Munson suggests that the expectoration of lung stones may, like the passage of kidney stones, bring relief, which opinion, he says, "is humbly submitted to those more skilful and experienced to determine."

LEVERETT HUBBARD

Leverett Hubbard, who also reports two cases, was a medico-military worthy commonly known as Colonel Hubbard. He commanded the second regiment of militia from 1773 to 1775, and is described as prompt, bold,

efficient, prepossessing and cheerful. He was a man of great energy and endurance and evidently, as Russell says, "the peaceful laurels to be won in a daily routine of calomel, ipecac and bark were not sufficient for his ardent temperament."

His first case, one of gangrene of the scrotum, is interesting from an etiologic standpoint and also on account of the extent of the tissue involved and the favorable outcome. The patient, a temperate tanner and shoemaker of forty, was taken with an intolerable pain in the left groin for the relief of which "a plaister was applied, formed of the oily dirt which swine leave on fences after rubbing." Though the published report does not say so it is apparent from the original record on the minute book that the plaster was applied on the advice of his wife who had the recipe from a lady friend. The result was an extensive gangrenous process, involving the perineum, the penis and the scrotum, which finally got well under the usual antiphlogistic regimen with multiple incisions and removal of the necrotic material. During the process the testicles and prostate gland were exposed and the former became adherent to one another so that they resembled "a twin peach or apple." The treatment was an example of excellent conservative surgery. Knowing as we now do the dangerous bacterial flora of the hog we can but wonder that the patient escaped with his life, particularly as metastatic abscesses developed. It is to be noted that in forty-nine days the patient took fifty-eight ounces of "that sovereign remedy, the bark." Hubbard's second case was that of a fetal monstrosity with a teratoma which the author describes in considerable detail, illustrating his description with a very presentable engraving, the only illustration in the volume.

BENJAMIN GALE

Benjamin Gale of Killingworth was a dependable and Godly practitioner whose epitaph summarizes his career; it follows:

"In memory of Doct. Benjamin Gale, who, after a life of usefulness in his profession, and a laborous study of the Prophesies, fell asleep May 6th, A.D. 1790, Aet. 75, fully expecting to rise again under the Messiah, and to reign with him on Earth. I know that my redeemer liveth, and that he shall stand at the latter day upon the earth, and mine eyes shall behold him."

Doctor Gale describes the perigrinations of a mad dog which, starting in the northern part of the town of Killingworth, passed through the east part of the town of Guilford, doubled on his course, passing again through Guilford on the post road, and was finally killed in Saybrook. During his journey the dog bit fifteen or sixteen cattle, hogs or other dogs and attacked two children, on one of whom he inflicted a lacerated wound "in the vertebrae of the neck." The other, a girl of eight or ten years of age was bitten through her clothes on the hip, only one tooth perforating the skin and drawing blood. Doctor Gale, correctly assuming that the child bitten in East Guilford would fall under the care of an old student of his, Doctor Todd, wrote him details as to treatment. He then hunted up the girl bitten in Killingworth and offered his services gratis as the mother of the child seemed quite unconcerned and apparently regarded the bite as a matter of little moment. The treatment consisted of a poultice in the case of the slight wound of the hip and scarification and caustics in the severer one, followed

in both instances by the internal administration of turpeth mineral several times repeated in sufficient quantity to produce copious emesis. This medication was recommended by a Doctor James, who had never tried it himself, to Mr. Floyer, who had tried it successfully on mad dogs. Doctor Gale notes that neither child developed rabies and assumes that this was due to the medication, though it is now known that not more than fifteen per cent of those bitten develop the disease. The report brings out the fact that hydrophobia had appeared in the Northern states a few years previously and it also throws light on the opinions then current concerning this fatal disease. Gale says that "The saliva of a mad dog, when mixed with the reflux blood, is known to be a slow but deleterious poison, and unless relieved by art, brings on a train of grievous symptoms, which terminate in death." He also notes that all of the animals which were not killed after being bitten by the Killingworth dog "run mad and died, except one sow which suckled a number of pigs, six or eight week old; she was bit on the tip of one ear, which was perforated by one tooth only. The sow nor her litter of pigs were in any perceptible manner affected; which, I conceive," says he, "was owing to the poison passing into the blood, being immediately drawn off by the lacteals, and being disseminated among the whole litter of pigs, before it had contaminated the whole mass of blood, it might not affect either sow or pigs; as it is well known the most deleterious poison may be taken in so small a dose, as not to injure the animal machine."

ELNATHAN BEACH

Elnathan Beach of Cheshire, who reports a case of "Puerperal Fever successfully treated with the Bark," was born in 1760 and died in 1801. He is said to have been active, intelligent and competent, and was a politician as well as a physician. He was a member of the Connecticut General Assembly in 1795 and moved to Marcelus, N. Y. in 1796 where he opened a store for dry goods, groceries and medicines. He was elected sheriff of Onondaga County in 1799 and held the office to the time of his death.

His case report shows good powers of observation and is an accurate description of a severe case of puerperal sepsis with the unusual feature of extensive involvement of the abdominal parietes. The patient recovered after the administration of one and a half ounces of the bark daily for a few days, though we feel dubious about accepting Beach's view that it was the bark which cured her.

ABRAHAM TOMLINSON

Abraham Tomlinson of Milford was born in 1738 at Woodbury and died in 1816. He was evidently a man of parts, was repeatedly elected a Fellow of the State Society from New Haven County, and evidently had the full confidence of his fellow townsmen, as his name is often found in the Milford town records. He trafficked with the West Indies and left a good estate. He was a member of the Committee of the State Medical Society which examined into the virtues of the Stafford Medicinal Spring and which reported that it contained "valuable medicinal properties." He was, judging from the records, the type of man who is "always on the job."

His report concerns two cases of foreign body in the gullet, then called the "gula," and indicates that "Salted flesh," presumably pork, and "beef and cabbage" formed part of the diet of that day. He succeeded in dislodging the offending morsels in both instances by the simple expedient of lubricating the parts with oil and following this procedure with an emetic. In both cases other practitioners who preceded him had unsuccessfully used other methods. The report shows him to have been a practitioner of judgment and ingenuity.

LEVI IVES

Levi Ives, of New Haven, the progenitor of the well-known Ives family, was born in 1750 and died in 1826 of angina pectoris. As a child he is said to have had epilepsy and for this reason was sent to live with Eneas Munson. After his recovery at the age of 16 he took up the study of medicine under Munson and became an efficient surgeon. He was active in military affairs, not only as a regimental surgeon during the Revolution, but also as a participant in the fight with the British at Allingtown, from which he luckily escaped unscathed. He was at Quebec with a Connecticut regiment when Montgomery made his celebrated assault. He was also politically active and served as selectman, councilman and justice of the peace. He is said to have been the first to discover the true pathology of croup and as proof exhibited a membrane which had been coughed up.

His one communication relates to a case of accidental poisoning by corrosive sublimate, the fashionable agent of the twentieth century suicide. The report is very brief and contains little in the way of comment. It is, however, a fairly accurate description of the symptomatology of sublimate poisoning so far as it goes.

HEZEKIAH BEARDSLEY

Hezekiah Beardsley, the brother of Ebenezer and Gershom Beardsley, was born in Stratfield in 1748, practiced in Southington and Hartford and finally moved to New Haven in 1782. He apparently practiced but little in New Haven, as he did not sign the agreement covering fees and consultations. He was associated for a time with his brother Ebenezer in his drug business. He was a good observer and a clear thinker, and finally died in 1790 of the same disease which carried off his brother Ebenezer, pulmonary tuberculosis.

His one reported case, observed in Southington, will probably keep his name and fame alive after many of his more prominent and successful confreres are forgotten. His title is "Case of a scirrhus in the pylorus of an infant," and he describes "clearly and accurately," as Osler says, the first recorded instance of what we now call hypertrophic pyloric stenosis. His description of the symptoms is classic, but he did not observe the visible peristalsis and palpable tumor which are so commonly found. Osler republished his article in the *Archives of Pediatrics* in 1903.

Considering the pamphlet as a whole we may truthfully say that it was a worthy effort and compares favorably with similar publications of its time. Naturally it reflects the beliefs and theories of the day, and considering that

it appeared in a period of theories and systems it is surprisingly rich in accurate clinical observation and logical deduction.

As contrasted with similar reports of the present day it is, of course, deficient in the accurate laboratory data of the late nineteenth and early twentieth centuries and to a considerable extent wanting in detailed descriptions of physical findings. The language is to our ears quaint, still tinctured with Latin equivalents for simple medical terms, and rich in allusions to "temperaments" and "habits," the significance of which we probably underestimate at the present. The therapy still smacks of the age of bleeding, purging and puking and contains many terms strange to our modern ears. We need only mention "testaceous powders," "Emmolient clysters," "alexepharmics," and "epithems" to emphasize this point. The volume can be recommended to those who are interested in the methods of work and the modes of thought of their professional ancestors of four generations ago.

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IONTOPHORESIS WITH ZINC PEROXIDE IN THE TREATMENT OF INDOLENT ULCERS

A Preliminary Report

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PREVIOUS TO 1910 several reports occur in the literature of the successful use of zinc peroxide in the treatment of chronic ulcers.¹⁻⁴ In the interval between 1935 and the present time, Meleney⁵⁻¹² and his co-workers have repeatedly reported favorable results with zinc peroxide in a considerable number of wounds. The use has been primarily to accelerate the healing of chronic, undermining and burrowing ulcers due to anaerobic and microaerophilic haemolytic streptococci in surgical infections. Other surgeons have obtained similar good results with zinc peroxide.¹²⁻¹⁶

The writer had occasion to observe Doctor Meleney's technic of application of zinc peroxide used in a case of wounds associated with transverse myelitis. The patient had developed five deep decubitus ulcers over the sacrum, both buttocks and both trochanters. All ulcers were deeply undermined and partly connected with one another by wide subcutaneous channels. After six months of this treatment, all the ulcers were cleaner in appearance, the one over the sacrum was no longer undermined, but the communicating channels still existed.

At this stage positive galvanism was introduced into the treatment. Over the zinc peroxide paste a gauze pad saturated in saline was placed, an electrode applied and this attached to the positive pole, an indifferent electrode placed elsewhere and the current was permitted to flow. Within seven weeks all the ulcers were completely healed with no residual channels or fistulae.

This very marked improvement, so definitely cause and effect, stimulated further use of the method.

In all fifteen patients have been treated. All were chronic indolent ulcers, as decubitus and varicose ulcers, and infected sores of various etiologies.

Results:

In fourteen cases complete healing was obtained. In the other case, a pressure sore on the dorsum of the foot did not heal with treatment. Subsequent

exploratory operation revealed an underlying osteomyelitis and not a pure soft tissue lesion as believed.

The result in these sequential cases has been so uniformly successful that the author and his co-workers are continuing the investigation further. An attempt will be made to analyze the process further and determine what factors are involved in the healing of previously indolent ulcers when treatment with zinc peroxide iontophoresis is given.

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(Concluded on page 686)

From the Physical Therapy Department of the Neurological Institute, New York City, N. Y.

DIAGNOSIS BY GASTROSCOPY

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IN THE STUDY of internal disease, no one can deny the importance of a careful history, a complete physical examination, and various pertinent laboratory studies. These different approaches toward an accurate diagnosis assume varying degrees of importance, depending on the disease process and the organ involved, but they are all indirect methods and are therefore usually limited. Direct study of a diseased organ is obviously invaluable, and gastroscopy enables one to examine directly and with remarkable clarity the interior of the stomach. The gastroscope is as essential in exact anatomic diagnosis as the ophthalmoscope, the bronchoscope, the cystoscope, and the sigmoidoscope, to mention only a few of our indispensable diagnostic instruments.

It is of some interest that of the two important morphologic methods of examining the stomach, although the indirect method of roentgenology has reached a higher degree of perfection, gastroscopy is the older. The first futile efforts to view the interior of the human stomach through a tube were made by Kussmaul in 1868. Attempts to construct a useful gastroscope were continued by many men with varying success until 1922, when a satisfactory rigid closed instrument was perfected by Schindler, who did more to develop modern gastroscopy than any other investigator. Much valuable information was obtained with the rigid gastroscope and the foundation was laid for future investigation. However, the real danger of esophageal perforation was a great handicap to further development of gastroscopy, and it was not until 1932 that this examination became safe with the perfection of the closed flexible gastroscope by Schindler and Wolf, the latter an expert optical worker. Never before had it been possible to see through a curved diagnostic instrument.

The Wolf-Schindler flexible gastroscope is a closed tube 77 cm. long; the upper rigid part is 8.5 mm. in diameter and 34 cm. long, and the lower flexible part is 12 mm. in diameter and 43 cm. long. An elastic rubber finger tip acts as a safe guide, brilliant illumination is provided by a small electric bulb, and the objective protrudes about 1 mm., so that it is wiped clean as it goes through the cardia and kept clean by wiping on the posterior wall of the stomach on which the gastroscope rests. The flexible portion always extends a few centimeters above the cardia even after the fullest introduction, and it contains numerous convex lenses, of which there are 48 in all. The image made possible by the complicated optical system is distinct, sharp, erect, and right sided, even when the flexible part is bent up to 34 degrees. There is some magnification close to the objective, with diminution beyond 3 cm., at which the true size is seen. The stomach is inflated with air through the gastroscope to make visualization possible.

The technic of introducing the gastroscope is not formidable and not necessarily a hospital procedure. Indeed, it is preferable to carry out the examination in the office or the clinic, since this aids immeasurably in allaying the patient's apprehension. Preparation in the average case consists simply in omitting breakfast after a good night's sleep. After a hypodermic of codeine and atropine to depress the gag reflex and diminish salivation, the right side of the mouth, tongue, and throat is swabbed with 2% pontocaine and the hypopharynx is sprayed with the same solution through a special tube. After the stomach is emptied by gravity through a large stomach tube, the examination is carried out. All the preliminary steps and the gastroscopy itself should be carried out by the same individual, preferably the gastroenterologist, who in the course of talking with and examining the patient has gained his confidence; the relaxation of the patient thus ensured contributes most to a successful visualization with a minimum of discomfort. In the average case the discomfort is considerably less than that experienced during cystoscopy, bronchoscopy, or eso-

From a symposium on Gastro-Enterology presented at the Annual Meeting of the Connecticut State Medical Society, Hartford May 22-23, 1940

phagoscopy. As a matter of fact, Schindler has gastroscoped one man sixty-five times, and most patients consent readily to repeated examinations.

The contraindications to the passage of the gastroscope must be rigidly observed. It is not only difficult to examine an uncoöperative patient, but also dangerous to the gastroscope. Aneurysm of the aorta, mediastinal tumor, and obstruction of the esophagus or the cardia are absolute contraindications, but they are readily ruled out by the passage of the large stomach tube and preliminary fluoroscopic examination of the chest. Furthermore, the gastrointestinal x-ray examination, which is usually done, can help rule out these contraindications by being done a few days before. Esophageal varices are also an absolute contraindication. Because of the danger of perforation through a friable stomach wall or a perforating ulcer, corrosive gastritis due to chemicals and abdominal rigidity or fever in abdominal disorders are also absolute contraindications. Among the relative contraindications which must be evaluated in each case are cardiac complications, marked scoliosis, kyphosis, or arthritis, and untreated jaundice.

Gastroscopy should be done in all cases of chronic dyspepsia whose symptoms are unexplained. In this connection, gastroscopy has been most impressive in the large group of patients who are dismissed as neurotics, functional dyspeptics, or cases of nervous indigestion because all the usual examinations, including roentgenology, have been negative. Many of these patients show a definite unmistakable gastritis which adequately explains their symptoms. In contrast to the normal stomach mucosa with its bright orange red color and few whitish patches of mucus mixed with air bubbles, one sees a distinctly abnormal mucosa. In chronic superficial gastritis, there are patchy areas of reddening, edema with increased highlights, thick gray or whitish yellow exudate, occasional small grayish white erosions, and a tendency to bleed. Chronic atrophic gastritis presents a quite different picture, with networks of branching submucosal vessels showing through a thinned grayish green mucosa which is frequently the site of mucosal hemorrhages. Chronic hypertrophic gastritis is characterized by a swollen, dull, loose, and spongy mucosa with irregular nodulation, segmentation of the folds which may be increased in size and number, pseudopolyps, and small or large hemorrhages. At the present time, chronic gastritis can be diagnosed adequately only by gastroscopy.

There are many other diagnoses possible only with the gastroscope. Unexplained bleeding may be due to gastric varices, mucosal hemorrhages, or hemorrhagic erosions. Gastroscopy is invaluable in helping to decide whether a chronic gastric ulcer is benign or malignant. A benign ulcer stands out as a sharply circumscribed white or yellowish white area with a rounded edge, a smooth depressed floor, and undermined borders; it is readily differentiated from a malignant ulcer with its heaped-up wall, irregular edge, and irregular dirty greenish, brown, or reddish floor. Benign polyps are readily distinguished by gastroscopy. It is often possible to see a small carcinoma not apparent by x-ray examination of a patient with unexplained symptoms, and gastroscopy can be an important aid in the diagnosis of cancer of the stomach early enough to increase the chances for cure by resection. Furthermore, it is often possible to determine whether or not a carcinoma is resectable by seeing the extent of the malignant infiltration. The polypoid carcinoma and the non-infiltrating carcinomatous ulcer are usually resectable if not too near the cardia. The infiltrating carcinomatous ulcer and the diffusely infiltrating carcinoma have a much poorer outlook for operative cure, and gastroscopy in these cases will often make an exploratory laparotomy unnecessary. Gastroscopy is important in following the healing of gastric ulcer, a matter usually of several months in contrast to the apparent earlier disappearance of the ulcer niche by x-ray criteria. In the post-operative stomach, one can determine whether the patient's symptoms are due to a marginal ulcer, a recurrent carcinoma, or a post-operative gastritis which is usually quite severe and the most common cause.

It has been possible to review briefly only a few of the important situations in which gastroscopy can be invaluable. Further investigation will undoubtedly revolutionize the handling of many diseases of the stomach. One must always remember, however, that gastroscopy cannot replace roentgenologic study but should be combined with it, especially in view of the fact that negative findings are of little value because there are three small but important blind spots on gastroscopy: part of the lesser curvature of the antrum beyond the angulus, the strip of posterior wall on which the gastroscope rests, and part of the lower pole of the stomach. Nevertheless, gastroscopy will continue to be as indispensable to the study of the stomach as cystoscopy is to the study of the bladder.

(Concluded on page 670)

THE NECESSITY FOR RECTO-SIGMOIDAL EXAMINATION

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THIS DISCUSSION could very well be prefaced by the statement once made by a well known proctologist to the effect that rectal examination should never be omitted in any case in which the patient complains of a deviation from the normal in the gastro-intestinal tract. At least one of our colleagues, and before him Doctor Osler, has emphasized for years and years the necessity for digital investigation in every case where a physician performs a physical examination. This, in the case of malignancies, will help to make a diagnosis in 80% of the neoplasms of the lower bowel wall. However, as approximately a fifth of the cases of malignancies is located above the reach of the finger, 20% of them will of course be missed. It does not need an Osler to preach to us that when an exact means of diagnosis is accessible to every practitioner, an error of twenty per cent is inexcusable.

It might be proper to spend a minute recalling to your minds the various steps in a proper recto-sigmoidal examination. These are inspection, palpation, digital examination, and anoscopic and sigmoidoscopic investigations. I have purposely left out the term proctoscopic, because a proctoscope may be an instrument from 2 to 6 inches long, and even a 6 inch instrument is not long enough for a proper recto-sigmoidal examination. A sigmoidoscope of at least 10 inches should always be used; personally I use a 12 inch instrument routinely, both in the office and in the clinic.

In addition to sigmoidoscopic examination, the barium enema may be used as a supplementary method of diagnosis. It should, however, always follow and *not* precede sigmoidoscopy, as it is much slower than sigmoidoscopy, causes just as much discomfort, is more expensive to the patient, and if used first, it interferes with visual examination by coating the bowel wall. Finally, in connection with sigmoidoscopic inspection, it is very simple and abso-

lutely without discomfort, to take a biopsy through this instrument, whenever it is indicated.

The symptoms which most frequently draw our attention to the necessity for a recto-sigmoidal examination are:—

1. Abnormal sensory symptoms, such as itching, tenesmus, and pain, either abdominal or peri-anal.
2. Discharge of blood, mucus, pus, or stool.
3. Deformity, either a protrusion or swelling, and
4. Change of bowel habit.

The last symptom is especially pertinent to our discussion this morning, as it is probably one of the first symptoms for which a patient may consult his physician. The complaint may be either diarrhea, or constipation of a few weeks or several months duration; or a former diarrhea or constipation may change to regularity of bowel habit. Any such variation should make us suspicious of a possible change in the lower bowel and should indicate the need for a recto-sigmoidal study.

I want to present briefly the high points in rectal examination so that I may correlate these findings with some of the obscure cases of so-called colitis and neurasthenias. I feel, and I am sure that most of you will agree with me, that the longer we practice medicine the more we find a cause for each trouble which was formerly blamed on "nerves."

Although many conditions may be discovered on digital examination, I will only mention three. (a) Neoplasms, of course can be palpated and I will speak of them later. (b) Impactions are important because, while they may be present for months, and be the cause of severe tenesmus, pain and diarrhea, they are so easy to diagnose, and equally simple to cure. And, I might add, they are very often overlooked. (c) Changes in sphincter tone are quite significant, for while loss of tonus may indicate a lesion of the central nervous system, increased muscle tone is usually caused by a painful lesion at the muco-cutaneous line. In this connection may I express my very definite opinion that uncomplicated hemorrhoids are rarely, if ever, painful.

The most common cause of pain and spasm is anal fissure. It is very important to bear in mind, however, that the muco-cutaneous border is the one place where cancer of the lower bowel is characterized by early pain. Primary luetic lesions of this region are seen at times, and I have always observed that they are quite painful. In connection with disturbances of the gastro-intestinal tract, fissurectomy and/or partial sphincterectomy, in selected cases, often give definite relief in many constipated patients, because they relieve the pain which is responsible for either the actual fear of a bowel movement, or the reflex constipation. Other reflex gastrological disturbances sometimes relieved by radical fissurectomy are spastic constipation, indefinite abdominal cramps, and even the pain which has been interpreted as a symptom of gastric ulcer.

It is probably just as well to combine the discussion of anoscopic investigation with sigmoidoscopy, as they are both visual means of examining the mucosa of the lower bowle. As I said above, this examination should always be made before the barium enema is given, as it is impossible to study the mucous membrane visually, if it is coated with a layer of barium. Moreover, very small lesions, invisible by x-ray examination can be seen by direct examination. Such lesions include small polyps, possibly the size of the head of a brass tack, or even smaller, and these are important because they may degenerate into cancer, as described by Swinton and Warren of the Lahey Clinic, in a recent article in the Journal of the American Medical Association.

These small polyps are a very common cause of the old bugbear "colitis," of the types known as "mucous colitis" and "nervous diarrhea." The reason for the symptom complex is quite simple and it is worth discussing the matter for a moment from a physiological standpoint. The polyp may act as a foreign body in the rectum and when it impinges on the opposed wall it all too often sets up a desire to defecate; or, the stimulation set up by the contact of the polyp against the opposite wall may result in chronic mucus formation and a resulting "mucous colitis." It is needless to say that many cases of long standing bowel troubles are cured by removal of these small bodies through the anoscope or sigmoidoscope.

Other conditions which are best diagnosed by sigmoidoscopic examination are the various types of ulcerative lesions encountered in the lower bowel. While these may be determined by x-ray in the later

stages, their presence is demonstrable, and they are much more easily attacked in the early stages, when they are discovered by the proctologist. Among these diseases, are chronic ulcerative colitis and tubercular ulcers. In addition, we must always keep in mind the great possibility of amebic dysentery, the remote possibility of diphtheria, gonorrhea, etc., and even the occasional presence of tropical diseases, such as schistosomiasis.

Naturally, cancer of the gastro-intestinal tract is one of the lesions which concerns us most deeply. We are often consulted by patients with rectal bleeding who are themselves suspicious of cancer, being educated to this suspicion either from personal experience, or from reading the great amounts of publicity given to malignancies in the daily press. The diagnosis of late cancer is, of course, a very simple matter. Just as simple, however, is the diagnosis of early cancer and in its early stages recto-sigmoidal cancer is curable, if one discovers it. One of the greatest indictments against our profession is the large number of patients who as is often said "develop cancer after a hemorrhoidectomy." The criminal part of this accusation and the pathetic part is that the cancer has *not* developed on top of the hemorrhoids. The probability is that in an exceedingly great number of cases a polyp or early cancer *was* present when the hemorrhoidectomy was performed, but because of absolute neglect, no sigmoidoscopic examination was done and the lesion was not seen. The indiscriminate use of proprietary or home remedies for gastro-intestinal symptoms, and the omission of visual examination on the part of the physician, is the main reason that cancer of the lower bowel is so often seen by the proctologist and general surgeon in its inoperable stages.

A Mothers' Charter

The American Committee on Maternal Welfare has published a "Mothers' Charter," designed to summarize the minimum demands made on society by the mothers of its children. This charter, drafted by Doctor Fred L. Adair of Chicago, chairman of the committee, is a complement to the "Children's Charter" drawn up in 1934 by the famous White House Conference on Child Health and Protection, and together the two "charters" stand as the general objective of the organization.

DISCUSSION

T. GRIER MILLER, M.D., *Philadelphia*

I CONGRATULATE you on the emphasis which has been placed in this symposium on certain extra-gastrointestinal causes of indigestion. Unfortunately, a tendency exists, even among so-called "gastro-enterologists," to blame all digestive disturbances on the stomach, duodenum, gall bladder and appendix. Yet this morning Doctor White and Doctor Fox have showed convincingly that mental, emotional and neurological affections may produce the syndrome of indigestion; Doctor Barron, that eye and ear lesions may do so; Doctor Weed and Doctor Morse that pelvic lesions may simulate appendicitis, while only Doctor Oughterson, Doctor Kushlan and Doctor Kleiner have talked about diseases of the alimentary tract itself.

In addition to the extra-gastrointestinal lesions mentioned as etiologic factors in the production of indigestion one might, with equal propriety, discuss diseases of the heart, the lungs and the kidneys, acute and chronic general infections, intoxications and metabolic disturbances. The mere recital of these relationships of the digestive system with conditions elsewhere in the body is sufficient to indicate how impossible it is to be a pure "gastro-enterologist" and at the same time a good physician. To diagnose cases with digestive symptoms one must be far more than a specialist in diseases of the digestive system; to treat them, even to be able properly to refer them for treatment to surgeons, psychiatrists, ophthalmologists and what not, he must be a physician with a far broader background of knowledge and experience.

It is an exceedingly interesting observation that relatively few patients with the symptoms of indigestion (epigastric pain or distress, eructations, regurgitations, nausea and vomiting) have any organic disease of the stomach: gastric ulcer, gastric carcinoma and gastritis, taken together, account, in my experience, for only 12 per cent of all the cases. Gall bladder disease, duodenal ulcer, affections of the colon and appendicitis are responsible for a great majority of the cases, but if only these are recognized one is missing many of the most fascinating cases: those that are due to extra-abdominal and to functional disturbances.

The functional cases, constituting about 17 per cent of our group, are often the most interesting ones, because so frequently after the elimination of an organic basis and an explanation of the neurosis, the patient is really cured; that is more than we can say for many of the patients with organic disease. The important point in these apparently functional cases is to be sure that organic disease has been ruled out; that, of course, cannot be assumed until all of the conditions discussed here this morning, as well as the more common affections of the digestive tract itself, have been carefully considered. Even then errors may occur.

I presume, however, that I am expected to discuss more specifically some of the organic diseases of the digestive tract that have been referred to. I agree with Doctor Oughterson as to the relative lack of effectiveness of our therapy in cancer of the stomach and colon; also as to the importance of earlier diagnosis. With reference to gastric malignancy I would place even more emphasis on the desirability of early x-ray examination. I think a month is too long to wait for such study in a patient with persistent symptoms of indigestion, whether cancer is suspected or not. Even ulcer, if it is to be treated most effectively, should be recognized objectively before such a time has elapsed. If the examination is negative and the symptoms persist, in spite of therapy and no obvious explanation, a second examination should be made after a few weeks. Because of the expense, however, I believe it is justifiable to be content with only a fluoroscopic study in most instances. The roentgenologists will not agree with me, but I have rarely seen a gastric ulcer or cancer found by films when a fluoroscopic study by a competent person was negative. When something is found, films should be made, for record and perhaps for additional information. When, on x-ray, study, an ulcer of the stomach is found it is then necessary to decide whether or not it is malignant. That may require frequently repeated x-ray studies, and perhaps gastroscopic inspection. Unless the lesion promptly subsides under ulcer therapy I believe it should be considered potentially malignant and subjected to surgery. I appreciate, however, that many ulcers of the stomach, especially of the mid-lesser curvature are benign; fortunately most of them heal rapidly.

From a symposium on Gastro-Enterology presented at the Annual Meeting of the Connecticut State Medical Society, Hartford May 22-23, 1940

Doctor Kushlan has discussed gastroscopy, including statements as to its helpfulness in the diagnosis of cancer. I agree with him that the primary indication for its use is an unexplained dyspepsia, provided x-ray study has first been made. Even Schindler tells me that he regards the x-ray as far more helpful in the diagnosis of ulcer or cancer, but he does feel, like Doctor Kushlan, that gastroscopy may help to identify some obscure lesions. At least the gastroscope may reveal a gastritis, sufficient to explain the symptoms, in some cases previously suspected of being malignant. Doctor Kushlan says that the benign and malignant ulcers are readily distinguished. I believe that can be accomplished in some cases, but not always in my experience, especially in those without infiltration of the stomach wall, the more hopeful operative subjects. In spite of what I have said I thoroughly approve of gastroscopy in all obscure gastric cases and believe that occasionally it may reveal an early carcinoma, missed by the x-ray.

Gastric analysis, even if it reveals an achlorhydria, is of relatively little help in the diagnosis of early cancer. Any degree of acidity may be found in cancer (5 per cent of our cases had hyperacidity and at least 50 per cent show some free acid after histamine). Achlorhydria, furthermore, may occur with benign polyps, in atrophic gastritis of various types and in the absence of any demonstrable disease.

The history in early cancer is not characteristic, usually indicating only some type of indigestion. The physical examination, if helpful at all, is so mainly in leading to some other explanation for the digestive symptoms. The important thing is always to have carcinoma of the stomach in mind and not to fail to x-ray and to re-x-ray from time to time until an explanation for the symptoms is discovered.

Carcinoma of the colon or rectum is the other lesion discussed by several of the speakers. It offers more hope for permanent cure, but here again early diagnosis is essential. Doctor Kleiner very properly has emphasized the importance of a digital examination of the rectum in every patient studied, no matter what the symptoms, and, in all those with symptoms referable to the lower bowel, a proctosigmoidoscopic study, followed by a barium enema.

Doctor Kleiner also has stressed the symptoms that commonly develop when the lesion is low in the large bowel. I think it is equally important to say that lesions of the right half of the large bowel often present, as their first symptoms, those of dyspepsia:

due to gastric motor disturbances. Just as soon as the ileum fails to empty itself normally into the cecum, and that may occur before there is organic obstruction, one gets a slowing up of small intestinal motility, with stasis in the duodenum and stomach. Heartburn, gaseous eructations, eventually epigastric discomfort, nausea and vomiting result. Thus, because the symptoms in a case are those of the upper digestive tract, one should never forget the importance of the barium enema along with the barium meal.

Anemia also commonly occurs in connection with lesions of the right half of the colon, and this occurs independently of blood loss. I had a patient with digestive symptoms and an anemia, suggestive of the primary type, for several years before we found, by x-ray, a large polyp in the ascending colon, proved at autopsy to be malignant. She never had gross bleeding. I have found that the anemia decreases with the downward position of the lesion in the colon.

In conclusion, let me say that the approach to the study of human disease from the viewpoint of the digestive tract is highly interesting, but that, in my opinion, no one should undertake it with the idea that he can limit his attention to the various parts of that system and at the same time be a good physician.

DIAGNOSIS BY GASTROSCOPY

(Continued from page 666)

A few representative references from the large and constantly growing literature are appended.

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CONGENITAL UROLOGICAL ANOMALIES

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CONGENITAL ANOMALIES are probably more common of the urinary tract than of any other system or organs of the body. Some are very simple and require little or no treatment while others are very distressing and the treatment requires very extensive surgery. These anomalies vary from such a common thing as phimosis to the very distressing case of extrophy of the bladder.

Congenital anomalies are generally seen by the general practitioner first. They are also seen by the obstetrician and very frequently they are diagnosed a few years later by the pediatrician. The urologist almost never sees them first.

Phimosis is the most common of these anomalies and this condition varies from slight difficulty in retracting the foreskin to almost a complete constriction. Many patients avoid a circumcision in early life only to be tortured in old age by an infection under a tight foreskin. A circumcision should be advised whenever there is any indication. There are two things to remember, first, that very troublesome adhesions may develop between the foreskin and glans. This occurs more often after using the clamp method in removing the foreskin. It may be prevented by frequently retracting the foreskin after operation or using vaseline gauze to prevent the surfaces sticking together. The second important thing to remember is not to remove too much tissue and especially not to remove the redundant foreskin in cases where a plastic operation will need to be done a few years as in congenital defects of the urethra.

Undescended testes are very common and have received the most attention in recent years. This condition is easily recognized. The type of abnormality, however, is very important from the standpoint of treatment. First, we recognize that group of cases where no mechanical factors of obstruction are present. Only these cases are amenable to hormone treatment. Both the male sex hormone and the

gonadotropic hormone of the anterior lobe of the pituitary are effective.

One may expect to obtain results in about 50% of these cases after the use of an average of four thousand rat units of the hormone. Treatment is usually started after the age of seven and is best given before puberty. Flushing of the genitalia and enlargement of the testes and penis are common symptoms following this treatment.

One should not use hormone treatment on the following four groups of cases:

1. Where a hernia or hydrocele is involved.
2. Where mechanical obstacles are present.
3. Migrating testes.
4. Aberrant position of the testis.

The testes may be found in aberrant positions such as the femoral region, above the symphysis or even in the perineum. The testis may have descended only partially due to a short spermatic cord or its accompanying vessels. In these conditions it is obvious that the hormone treatment is useless.

Cases of undescended testes that have not responded to treatment should be considered as a surgical problem and it is well to keep in mind that the undescended testis is apt to be sterile and at times becomes malignant.

Congenital strictures of the urethra occur and usually all that is necessary is to dilate them at intervals. Congenital dilations, diverticula, and so called "valves" of the urethra occur but are rare.

Epispadias, an incomplete closure of the dorsal surface of the urethra, is an uncommon anomaly and is often seen with extrophy. This latter condition is the most important of all congenital lesions of the urinary tract and fortunately it occurs only once in about thirty-five thousand cases. It is easily diagnosed at birth. One finds a fleshy mass above the pubis covered with mucous membrane and oozing urine. Close examination will reveal the urethral opening spurting urine at intervals. The acknowledged treatment at present is the transposition of the ureters into the sigmoid and rectum. The more conservative method of transplanting the ureters to the skin in the flanks is seldom done as it leaves the patient draining urine constantly which is very distressing to him as well as to his friends.

Hypospadias, an incomplete closure of the ventral surface of the urethra is relatively common and one may find the external opening just back of the glans midway under the penis or at the penile-scrotal junction. Frequently there is a stricture of the external opening and this may require dilating even at birth. A plastic operation on the urethra, however, is best done after the age of seven. As stated before it is very important to save the redundant foreskin for this plastic operation.

Constrictions and congenital dilatations of the ureters are likewise not uncommon. They are frequently accompanied by marked dilatations of the renal pelves. The treatment is conservative and usually consists of dilatation or opening of the ureteral orifice but the prognosis in these cases is usually not good.

Duplication of the pelves or ureters is frequent and may be partial or complete. The hereditary nature of this anomaly is well demonstrated in one family which came under our observation where four sister and their mother all had some type of duplication of their ureters.

Other anomalies of the lower end of the ureter exist. The ureteral opening may be found in unusual places in the bladder, in the urethra, and at times in the vaginal cavity. In this latter condition the patient has incontinence which is usually the presenting symptom.

Ectopic kidneys are rare occurring about once in twenty-two thousand cases. This condition almost always escapes diagnosis until young adult life, since the urine examination shows nothing and the symptoms of pain and pressure usually come on after puberty. This lesion is most frequently diagnosed as a mass involving the pelvic organs, and often complicates pregnancy.

Other common place anomalies such as congenital hydroceles, spermatoceles, duplication of the urethra and penis are seen. Time does not permit further discussion of these lesions.

What Better Philosophy of Life?

The custom of presenting medals to those who have practiced medicine for fifty years in their own State is a gracious and pleasing gesture indulged in each year by the Maine Medical Association. Among the recipients at York Harbor this year was a tall rugged specimen of New England stock, Doctor George A. Gregory of Bar Harbor. In accepting this token of gratitude for a half century of service to his fellowmen Doctor Gregory replied with a philosophy which might well be adopted by our younger practitioners.

"In traveling this rough and rugged path of life my philosophy has been, and is, to get a reasonable amount of happiness out of each day. That one who does not get fun and enjoyment out of each day in which he lives needs to reorganize his life and the sooner the better, for pure enjoyment throughout life has more to do with one's happiness and efficiency than almost any other single element.

"So far as age is concerned, that is distinctly an individual matter, determined biologically by heredity, physiologically by environment and behavior, and practically by the accident of destiny. It is the most individual thing in existence. Years on the calendar are very different from years in the soul.

"I believe the recipe for happiness to be: Enough money to pay the monthly bills you acquire; a little surplus to give you confidence; a little too much work each day; enthusiasm for your work; a substantial share of good health; a couple of real friends and a wife and children to share life's beauty with you.

"Harking back to 1891, the year I graduated from the Maine Medical School, I have always remembered the closing of the last lecture given by our beloved Professor of Surgery, Doctor Stevie Weeks, and they have been of great value to me. He said: 'Gentlemen, field of labor is wide. Go out like men and be strong'."

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ACUTE ALEUKEMIC LEUKEMIA

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ACUTE ALEUKEMIC LEUKEMIA is an atypical form of acute leukemia, leukopenic in nature, which may or may not be an integral part or stage of the acute or chronic leukoblastic proliferation. The same clinical picture is present as in the typical forms with the high counts; the only difference found is in the enumerated total white count. This condition may present itself as a separate stage in the course of an acute leukemia with its typical high count, during the course of chronic leukemia, or primarily in which case the white count may never reach normal limits. It is usually seen in atypical leukemic processes, but may follow radiation or the use of agents which depress blood cell activity. It is intended that discussion shall center primary about acute aleukemic leukemia, afflicting those individuals who have previously been well and have had no related signs or symptoms to leukemia.

This dyscrasia affects chiefly children and young adults, it being seldom seen after the fourth decade of life. Males are afflicted more frequently than females in the ratio of two to one. The cause of leukemia, typical or atypical, is unknown. It is generally believed to be neoplastic in nature; however, some advocate that infection, fulminating in type, may be the cause. A plausible theory which may explain the level which the leukoblastic cells reach considers the spleen and other phagocytic tissues. If these organs are able to remove from the peripheral blood stream immature blood cells as quickly as they are released, it is only natural to surmise that a leukopenic condition is to be the end result. However, if the pace is too rapid, a leukocythenic leukemia results.

The following types of aleukemic leukemia are known: myeloid, lymphatic, and monocytic. The myeloid type is reputed to be the most common variety, perhaps because it has become recognized that myeloblasts exist in several bizarre forms. There is the large myeloblast or macromyeloblast, the average sized myeloblast or normomyeloblast and the small myeloblast or micromyeloblast. The latter

cell may be no larger than the lymphocyte, having only a small zone of peripheral cytoplasm about a dark staining nucleus. Occasionally no cytoplasm may be visible at all and the cell is identified as a lymphocyte, hence the condition could be diagnosed "lymphatic leukemia."

It is the general train of thought that in primary acute aleukemic leukemia the myeloblast is the dominant cell; whereas, in cases where the aleukemic phase is merely a part or stage of the varying blood picture, the myelocyte is the dominant cell.

In leukopenic leukemia "hiatus leukemicus" often exists. This is a blood picture which is characterized by the presence of only fully segmented polys and myeloblasts.

Diagnosis of primary acute aleukemic leukemia is made hematologically and clinically. Study of the blood smear, if the peroxidase stain has been used, reveals cells which give the peroxidase reaction—polys, eosinophils, myelocytes, myeloblasts and endothelial leukocytes—these all contain sharply defined blue granules. Such granules are lacking in lymphocytes. However, in some cases the cells are so very immature that the test fails. In most cases it is best to be content with a diagnosis of acute leukemia. If the case is myelogenous in origin, a sufficient number of myelocytes should place one on the right track.

Clinically, primary acute aleukemic leukemia is characterized by many diverse symptoms. The onset of the present illness is usually vague unless there is the history of the chest or manubrial pain. In all events the patient has not felt well for an indefinite period and he comes for consultation. The first complaint may be pain in the sterno-clavicular articulation or in the vicinity of the manubrium of the sternum. In the majority of cases on the initial visit to the physician the patient reveals either petechiae, ecchymosis, bleeding gums, sore throat or those complaints which may emanate from anemia as edema, weakness, palpitation, vertigo, pallor or shortness of breath. Such an aggregation of symptoms should place one upon the alert.

The temperature is usually elevated and shows a marked daily variation, fluctuating several degrees. The pulse rate is elevated as it would be in any

anemia. The respirations likewise depend upon the degree of anemia and such complications which may arise as pulmonary hemorrhage, infarction or complicating infection.

Physically there are variations, depending upon the advancement of the condition. There may be bleeding in the lungs, serous cavities, retina, gums, throat, vagina, joints, skin; in fact, in any part of the body. Allied with the already mentioned factors may be hepatomegaly, splenomegaly, adenopathy and pallor.

Laboratory studies reveals a leukopenia, anemia, immature blood cells, thrombocytopenia, elevated sedimentation rate, prolonged bleeding time and usually a normal clotting time. There is of course achromia, and possible anisocytosis, poikilocytosis and polychromatophilia.

In the differential diagnosis many conditions should be ruled out, namely: pernicious anemia, Vincent's oral sepsis, agranulocytic angina, subacute bacterial endocarditis, Banti's Disease, aplastic anemia, hemorrhagic states, chloroma and infectious mononucleosis.

Pernicious anemia is usually characterized by achlorhydria, glossitis, spinal cord symptoms and a hyperchromic macrocytic anemia. The blood picture varies greatly with the stage of the disease but there is a hyperchromic erythrocytic picture. The white count is usually normal as is the differential and the platelets are little affected. The response to liver extract is well known.

Vincent's oral sepsis is a destructive lesion of the buccal cavity which is associated with the presence of a fusiform bacillus and spirochete. The blood picture is normal but it is necessary for study to exclude agranulocytic angina.

Agranulocytic angina shows a remarkable disappearance of the granular cells and a low total white count. A differential point of value from acute aleukemic leukemia is that the platelet is high in agranulocytosis and low in leukemia as a rule. There are no immature white cells. Ulceration of the gums, tongue and throat are usually present.

Subacute bacterial endocarditis has these principle clinical features: continued fever, pain in the left upper quadrant, probably due to splenic emboli, evidence of multiple emboli, endocarditis, positive blood cultures, splenomegaly, and clubbing of the fingers. Hematological study reveals progressive anemia.

Banti's disease in the usual case is identified by the following triad: splenomegaly, secondary anemia

and leukopenia, and gastric hemorrhage. Cirrhosis of the liver follows with ascites. The blood picture shows no immature cells.

In aplastic anemia, the type is normocytic and normochromic with no normoblastic regenerative changes. The bone marrow is typically aplastic. All of the formed elements of the blood are low and on account of the thrombocytopenia, purpuric hemorrhages become manifest and it may be difficult to distinguish this entity from true purpura.

Profuse bleeding or petechial hemorrhages often are the first manifestations of aleukemic leukemia and this may lead to a diagnosis of one of the hemorrhagic states. However, the purpura shows a normal white count and a secondary anemia only when the blood loss has been great enough to manifest such. The platelet count, bleeding and coagulation times, all serve in the differential diagnosis.

Chloroma forms a link between leukemia and tumor growth. There is a leukemic blood picture and green tumors are found in the flat bones especially in the face and skull, hence often producing exophthalmus. These tumors may also be in the liver, kidneys, muscles and skin. Splenomegaly and lymphadenopathy are often seen. Hematologically the picture is that of leukemia but the total white count is as a rule normal. This entity is seen in children and young adults.

Infectious mononucleosis is an acute infectious and contagious disease in children and young adults, occurring often in epidemics and in the spring months. It is characterized by malaise, fever, a peculiar type of pharyngitis and sometimes conjunctivitis, marked enlargement of the lymph nodes and spleen and a striking alteration in the leukocyte formula. There is usually a leukocytosis, a relative and actual neutropenia and a marked mononucleosis which may reach 99% of the total count. There is, however, not the rapidly developing anemia and platelet change, and the clinical course is milder, benign and harmless generally. The heterophile antibody test is of course specific for infectious mononucleosis. The titer varies in intensity depending upon the severity of the case. Any dilution above 1:64 is considered diagnostic if there is no history of serum sickness. The antibody titer may be positive up to a dilution of 1:4000.

A brief summary of several cases seen are as follows:

Case I. A two and a half year old male J. S. was admitted to the Stamford Hospital with the chief complaint, of pallor,

weakness, dyspnea and lethargy. Several weeks prior to admission the patient had received a periodic physical checkup and it was found at the time that only a very mild anemia existed. Upon admission examination revealed the following: extreme sallow lemon-colored skin, generalized lymphadenopathy, a small subcutaneous ecchymosis on the right leg, splenomegaly, hepatomegaly, a slightly enlarged heart, systolic and diastolic murmur over the precordium, diaphragmatic pleural friction rub, weakness and dyspnea.

A blood count revealed 30% hemoglobin, 1,560,000 red cells and a white count of 4000. There was marked achromia, anisocytosis, poikilocytosis and polychromatophilia. Megaloblasts and normoblasts were present. The coagulation time was three minutes and the bleeding time sixteen minutes. Differentially there were 25 undifferentiated blast cells, 52 myeloblasts, 18 lymphocytes, 4 polys and 2 juveniles. The platelet count later enumerated was 60,000.

Daily blood counts until death revealed that the hemoglobin percentages varied between 26% and 44%; the red count between 1,370,000 and 2,700,000; the white count between 1000 and 4000 and the platelet count between 48,000 and 97,000. Three blood transfusions were given.

The time elapsed between admission and death was 14 days. The temperature, pulse, and respirations showed a very marked fluctuation. The Bence Jones protein determination was negative; all blood cultures were sterile and the stool had four plus occult blood.

Roentgenological examination of the long bones and the skull revealed no evidence of any bone changes which might be associated with an acute leukemia. There was no bone or joint pathology.

Post-mortem examination revealed a profound anemia of the skin, which was a peculiar yellow color, suggestive of jaundice. The sclera were clear. There were two small purpuric spots over the left shin. Both lungs were free in the pleural cavity and showed a marked blanched, bled out appearance. Both lower lobes showed multiple hemorrhagic infarctions. The peribronchial lymph nodes were enlarged and hyperplastic. There were several large lymph glands in the axillae about the size of a peanut. The right heart was collapsed and the myocardium showed extreme anemia; all the valves were normal. The liver which had a peculiar yellow appearance was enlarged, solid and firm, extending four fingers below the costal margin. A deep prominent cleft separated the right and left lobes, consequently the left lobe was palpated and diagnosed clinically as spleen and the right lobe as liver alone. The spleen itself was normal in size and shape; the capsule was wrinkled and the pulp was not removed easily. The stomach contained some black "coffee-ground" material, otherwise there was no pathology with the exception of the anemic mucosa. The esophagus was negative. There was no free fluid or tarry substances in the lower bowel; however, in the upper ileum there were a few tarry flakes. Both kidneys showed a marked anemia; the ureters, bladder and adrenals were negative. The mesenteric lymph nodes were all greatly enlarged and firm. Sections of the spleen, liver, lungs, heart, bowel, bone marrow and lymph nodes were characteristic of acute myelogenous leukemia.

Case II. A forty eight year old male G. T. was admitted to the Stamford Hospital with the chief complaint of hemor-

rhagic diathesis and weakness. The present illness began two weeks prior to admission while the patient was on a sea cruise where it was noted that a slight injury to the wrist caused considerable swelling and a large ecchymotic spot. Weakness and dyspnea on slight exertion became manifest. Three days prior to admission his gums began to bleed and there were small hemorrhagic spots on the mucous membranes of the cheeks and on the tongue. Shortly after entrance to the hospital a right sided epistaxis developed which persisted for three hours in spite of treatment.

The family history was non contributory. He suffered from the usual childhood diseases, in addition to dysentery, diphtheria and appendicitis. There is a history of melena five years ago; however, the cause was never determined.

Physical examination revealed a well developed, well nourished, middle aged white male lying quietly in bed, in no apparent distress, who was anemic in appearance. All findings were negative with the following exceptions: A profuse nasal hemorrhage was present. There were many small ulcers on the mucosae of the cheeks, lips, gums, and tongue; blood was oozing from the gums. The extremities showed hemorrhagic areas. Generalized lymphadenopathy existed.

The temperature was normal on admission and fluctuated from this level to 103 degrees until death ensued. The pulse rate never exceeded 120. Respirations were never embarrassed.

The gum smear was negative for Vincent's organisms and the blood culture showed no growth. The urine at all times showed albuminuria, also rare to occasional white blood cells. Just prior to death there was gross hematuria and a shower of granular casts. The stool was negative for occult blood. The blood calcium level was 9.8; the icterus index 6.2 and the fragility test 0.46 to 0.34.

The blood work on admission was as follows: coagulation times 2½ minutes, bleeding time 1 minute, hemoglobin 74%, red count 3,480,000, white count 5,100, polys 49%, lymphocytes 50%, and monocytes 1%. There was slight achromia. The platelet count was 130,000. Daily blood counts were done and on the fifth day after admission immature cells were seen for the first time. At that time the white count was 4,850, polys 15%, lymphocytes 8%, monocytes 1%, myelocytes 10%, blast cells 57% and stab cells 9%. Marked polychromatophilia was present. Many normoblasts were seen. Two transfusions were given. Between the time of admission and death the hemoglobin varied between 54% and 84%; the red count between 2,130,000 and 4,190,000 and the white count between 2,700 and 6,850. Following the appearance of the blast cells, thereafter differentially, they constituted roughly 50% of the cells on the blood smear. The Wassermann was negative.

X-Ray examination of the chest revealed no cardiac or pulmonary pathology.

Thirteen days elapsed between the time of admission and death. The day prior to death, manifestations of a cerebral hemorrhage became obvious. Following this the patient became comatose and died shortly after.

Post-mortem examination revealed a forty-eight year old male whose tissues appeared quite anemic. Examination of the thoracic organ revealed the heart to be normal with the exception of an anemia of the myocardium. The lungs were air-containing throughout and showed very slight

congestion and edema at the margin of the bases. The bronchial tubes were filled with mucous and blood. There was no free fluid in the pleural cavity.

The gastro intestinal tract was slightly distended. The stomach contained food, blood and mucous. Examination of the remainder of the tract was essentially negative. The spleen was slightly enlarged, soft and had a hyperplastic appearance on cut section. The liver was normal in size and shape, anemic in appearance and on cut section the markings were distinct. The pancreas was normal. The right kidney showed recent hemorrhage into the pelvis and calyces. Otherwise examination was normal. The urinary bladder contained only a slight amount of blood stained urine. The prostate was normal. All of the intra-abdominal viscera had an anemic appearance.

Microscopic examination of the bone marrow, spleen, liver and lymph nodes demonstrated the characteristic changes found in acute myeloid leukemia.

Permission to examine the cranial contents was denied.

Case III. A thirty year old female E. T. was admitted to the Stamford Hospital with the chief complaint of a dull aching pain across the shoulders, back, and sternum with pain and swelling of the right sterno-clavicular articulation. On admission she was flowing rather excessively and passing small clots.

The present illness began approximately two months prior to admission with sternal and right sterno-clavicular pain. At that time the patient was admitted for examination and all findings were negative with the exception of an elevated sedimentation rate. No diagnosis was made. The pain eventually disappeared and the patient felt fairly well until several days prior to admission when the chest pain reappeared.

The family and past histories were non contributory. Physical examination was negative with the following exceptions: there was generalized adenopathy, small petechiae at the dental margins of the gums, tenderness across the right scapular region, which was exaggerated on coughing, low back pain, pain and swelling of the right sterno-clavicular articulation and small petechiae on both legs.

The blood count on admission was as follows: hemoglobin 70%, red count 3,840,000, white count 8,700, polys 67%, lymphocytes 30%, monocytes 2%, eosinophiles 1%. Other laboratory procedures carried out were as follows: Coagulation time 3 minutes, bleeding time 4 minutes, clot retraction time normal, sedimentation rate 58 mm per hour, platelet count 206,000, uric acid 2.9, icterus index 10, blood calcium 9.5, Vanden Bergh negative, gum smear negative for Vincent's organisms and a negative Bence Jones protein determination.

The red count between time of admission and death varied between 940,000 and 3,840,000, the hemoglobin between 14% and 70%, the white count between 1,900 and 10,800 and the platelets between 21,000 and 208,000. Repeated sedimentation rates during the course of illness were as follows: 58 mm per hour, 70 mm per hour, 75 mm per hour, 57 mm per hour and 80 mm per hour. Respiration during illness varied between 20 and 33, the pulse between 82 and 160 and the temperature between 99° and 103°.

Seven days after admission the leukemic picture became manifest. The peroxidase stain at that time revealed 44% lymphocytes, 42 granular cells and 14% blast cells.

The blood picture also demonstrated megaloblasts, normoblasts, polychromatophilia, poikilocytosis, anisocytosis and achromia.

Two transfusions were given but they were of no material benefit. Three days prior to death bleeding from the gums and vagina became profuse, weakness and drowsiness increased in intensity and the patient lapsed into a coma and died. Post-mortem examination was denied. The total time between admission and death was nineteen days.

Case IV. This is presented as a matter of interest. It is not a typical example of acute aleukemic leukemia as the three cases reviewed above. It is presented with the idea of showing that the leukapenic state may be a stage instead of a separate entity. In this case the white count rose from 4,950 to 42,050 in a period of four days and death followed on the following day.

This patient was a 28 year old male who was admitted to the Stamford Hospital with the chief complaint of pain, swelling and stiffness of the joints and general malaise. The present illness began two weeks prior to admission. The past and family histories were non-contributory. The physical examination was negative with the exception of the following: bilateral cervical adenopathy, decreased vocal fremitus in the right apex posteriorly, moist rales in the left apex anteriorly and the right middle lobe posteriorly, systolic murmur at the tricuspid area on exercise, hepatomegaly extending two fingers below the costal margin and pain and stiffness of the wrists, elbows, knees and ankles.

The blood count on admission was as follows: hemoglobin 64%, red count 3,840,000, white count 13,250, polys 77%, lymphocytes 17% and monocytes 6%. Moderate achromia existed. The sedimentation rate was 137 mm per hour; both Wassermann and urinalysis were negative and the throat culture was positive for hemolytic streptococcus.

Röntgenological examination of the chest revealed a negative diagnosis for tuberculosis; the slight accentuation of the lungs marking indicated only a moderate degree of bronchitis.

The temperature and pulse were both elevated during the entire hospital stay which was five days. At this time the patient felt much better and decided he could convalesce as well at home, hence he was discharged. The diagnosis at this time was acute rheumatic fever.

One month later the patient returned with the chief complaint of pain and swelling of the joints. There had never been complete relief from the previous complaints.

The physical examination was negative with the following exceptions: slightly injected throat, right cervical adenopathy, left cardiac hypertrophy, slight swelling of the left elbow and both knees, and three erythematous areas on the thenar eminence of the right hand which were suggestive of embolic manifestations.

The blood count on admission was as follows: hemoglobin 52%, red count 2,430,000, white count 8,550, polys 70%, lymphocytes 25%, monocytes 3% and plasma cells 2%. The sedimentation rate was 167 mm per hour. The urine was negative.

Three days following admission the leukemic picture became manifest. The total white count was 8,050, polys 43%,

lymphocytes 7%, myelocytes 37% and blast cells 13%. The peroxidase stain revealed 75% granular cells, and 25% non-granular cells. On this day for the first time the following were noted: pain in the left chest and left upper quadrant, friction rub on deep inspiration, epistaxis and chills. The following day the spleen became palpable for the first time.

Two days prior to death right cervical adenopathy of such magnitude developed that the speech was altered and phonation had a brassy nature. It was about this time that the white count became elevated, rising from 4,950 to 42,050. The myelocytes proved to be the dominant immature cells, averaging roughly 50% and the blasts approximately 12%.

Repeated blood cultures proved to be negative; three blood transfusions were given with no material benefit.

The temperature varied between 98.8 and 105.8 degrees, the pulse between 82 and 150 and the respirations between 20 and 28.

The total time between admission and death was thirteen days. The patient gradually lapsed into a coma and passed away. No permission for autopsy was obtained.

When the diagnosis of this dyscrasia has been made, there is very little that can be done for the patient. Transfusions are of only temporary benefit, hence the chief aim of the physician should be to make his patient as comfortable as possible. One of the most annoying and distressing features to the patient is the bleeding from the gums and throat. Topical application or spray of Fer De Lance Snake Venom to the bleeding areas temporarily diminishes or stops the bleeding. Pituitrin partially controls the uterine hemorrhage if it is present. Morphine should be given as often as is deemed necessary. Deep x-ray therapy is not indicated usually.

CONCLUSION

1. In acute aleukemic leukemia the enumerated total white count may vary from extremely low levels to the normal limits and there may be con-

CASE I

Day	1	2	3	4	5	6	7	8	10	12	14	Death
Hgb.	30%	28%	26%	27%	36%	30%	40%	44%	42%	40%	28%	
RBC	1,560,000	1,580,000	1,990,000	1,960,000	2,250,000	1,590,000	2,700,000	1,370,000	2,200,000	1,900,000	1,640,000	
WBC	4,000	2,150	1,900	1,900	2,000	2,800	3,850	1,600	2,600	1,600	1,000	

CASE II

Day	1	2	3	4	5	6	7	8	11	Death
Hgb.	74%	76%	72%	84%	69%	64%	82%	74%	54%	
RBC	3,480,000	3,480,000	3,350,000	4,190,000	3,520,000	3,260,000	3,440,000	3,010,000	2,130,000	
WBC	5,100	5,150	4,900	4,900	4,850	2,450	2,700	3,550	6,850	

CASE III

Day	1	6	7	8	9	10	11
Hgb.	70%	38%	44%	46%	40%	54%	54%
RBC	3,840,000	2,130,000	2,800,000	2,600,000	2,500,000	3,020,000	2,700,000
WBC	8,700	3,150	1,900	2,500	2,800	2,400	2,600

CASE III-CONTINUED

Day	12	13	14	15	16	17	18	Death
Hgb.	40%	43%	32%	28%	18%	20%	14%	
RBC	1,940,000	2,020,000	1,700,000	1,400,000	1,010,000	1,120,000	940,000	
WBC	4,500	5,000	10,500	10,550	9,700	9,550	10,800	

CASE IV

Day	1	3	5	6	7	8	12	13	Death
Hgb.	52%	48%	40%	38%				35%	
RBC	2,430,000	2,300,000	2,300,000	2,100,000				1,990,000	
WBC	8,650	8,050	12,000	6,900	5,000	4,950	42,050	62,000	

siderable difficulty in diagnosis, both from a hematological or clinical standpoint.

2. Diagnosis of leukemia should be made if there is a preponderance of immature cells, regardless of the count.

3. The treatment of leukemia is largely symptomatic.

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Registry of Medical Technologists

It has recently been announced that the Registry of Medical Technologists of the American Society of Clinical Pathologists has been moved from Denver, Colorado, to Muncie, Indiana. Since its organization in 1928 the Registry has been located in Denver, where its work has been carried on under the administration of its distinguished chairman, Doctor Philip Hillkowitz, and Mrs. Anna R. Scott, the registrar. The increasing burden of the office, together with a recent serious illness, prompted the resignation of Doctor Hillkowitz as chairman of the Board of Registry. His successor, who was chosen by the members of the Board to fill the vacancy, is Doctor Lall G. Montgomery, the pathologist of the Ball Memorial Hospital, of Muncie, Indiana. The Registry will be situated at the hospital.

Following the resignation of Doctor Hillkowitz, the Registry suffered a further loss in the retirement of Mrs. Scott, the registrar of the Board. Her untiring and capable services will be sadly missed by the Board as well as by her many friends among the registrants. The newly appointed registrar is Miss Carlita R. Swenson, who comes from Philadelphia,

where she has been associated with the United States Pharmacopoeia.

This event in the history of the Registry is a reminder that over twelve years have passed since the first handful of registrants received their certificates from the Denver office. Since then, under the skillful and friendly guidance of Doctor Hillkowitz and Mrs. Scott and their associates on the Board of Registry, the number of registered Medical Technologists has increased to the present impressive figure of 6,856. Twice a year this total is further increased by the addition of several hundred successful candidates from the spring and fall examinations held by the Board.

A further rapidly increasing responsibility of the Board of Registry is the investigation and approval of schools for the training of Medical Technologists. The standards adopted for the approval of these schools have been raised gradually during the past twelve years and yet at the present time there are more than one hundred and fifty schools which have met all the requirements and therefore are approved for the training of student technologists. In this important work the Board of Registry has received the invaluable assistance of the Council on Medical Education and Hospitals of the American Medical Association, who have very kindly assumed the expense and responsibility of making the surveys of the various schools who make application for approval.

The great success of the work of the Registry has been due in large part to the enthusiastic support which has been given the work by pathologists, hospitals, and educational institutions throughout the country. It is the hope of the Board of Registry and the Registry staff that the change in location will in no way interrupt the success of the work.

Improvements in Technic of Tonsillectomy

Until 1900 tonsillotomy was in vogue, then for a decade an extensive tonsillectomy became popular, and now for the past twenty years standards of removal of tonsils have been improved until a muscle free dissection is the common aim of all. Robert H. Fowler, M.D., of New York, in the Journal of the American Medical Association for August 2, reports the use of plastic flaps in performing tonsillectomies, thereby minimizing convalescence by partially covering the exposed portion with mucous membrane and obviating severe post operative pain and discomfort. Thousands of these operations have been done with no bad results.

TULAREMIA IN CONNECTICUT

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We herewith submit report of the first case of tularemia to make official appearance in the State of Connecticut.

CASE REPORT

The patient was a 49 year old adult white male press operator who was admitted in muttering delirium to the Veterans Administration hospital, Newington, Connecticut, on December 9, 1940. Previous medical, social and family history was irrelevant. Sixteen days previously on November 23 patient had gone hunting in the Salem-Colchester area with his 8 year old son and another man. He shot two medium sized Connecticut cotton tail rabbits and two partridges, and also picked up a large dead rabbit which he thought had broken its neck because of the way the head hung and because its body was still warm.

The partridges were given to the companion who ate them without ill effect. Our patient hung the three rabbits up outside his home in East Hampton, Connecticut, until Monday, November 25, when he skinned, bled and washed them and placed them in a salt solution for several hours, after which he cleaned them and placed them in a refrigerator. They were cooked and eaten on Wednesday, November 27. Patient buried skin and entrails in a pit near his home.

After an incubation period presumably of three days, patient complained of malaise on the morning of November 28. He partook of a Thanksgiving Day dinner, but shortly thereafter had to go to bed because of chills, headache, fever (103°F.) and malaise. His wife noted "festering" on his fingers when she put him to bed. A physician was called the next day and a diagnosis of "grippe" made. "High fever" was present first three days of disease, receded to normal on the fourth and recurred on the fifth, after which steady improvement permitted sitting up in chair for one half hour on December 6, the ninth day of disease. The next day he spent down stairs on a couch, feeling much better. On the eleventh day of disease headache and malaise were noted at noon and patient returned to bed. He apparently slept well and spoke rationally to his wife early the next morning, but at 8:00 A. M., couldn't recognize his daughter. His physician was recalled, noted delirium and recommended hospitalization. The patient was brought to hospital by ambulance at 4:30 P. M., the twelfth day of disease, with a diagnosis of "Acute Toxemia."

On admission the patient was seen by the Chief of the Medical Service, Doctor Edward H. Gibbons, who noted a well developed and well nourished 49 year old white male deliriously muttering as he stared out into space with a fearful expression on his face. Conjunctival injection was present. Pupils were equal and reacted well to light. Ears and nose were negative. Poor mouth hygiene was noted. Neck was negative. Chest mobility was good and equal. Respiratory rate was 24. Breath sounds were exaggerated throughout.

There were a few fine râles noted through lower posterior chest bilaterally. Pulse was 110, regular. Blood pressure was 138/88. Heart was not enlarged to percussion, sounds were of a good quality and there were no thrills, shocks or murmurs. Abdomen was somewhat distended. Neither liver nor spleen was palpable. Genitalia were normal. Lower extremities were negative. On the dorsum of the middle phalanx of the right middle finger and on adjacent areas of distal portions of index and middle fingers of the left hand there were indolent ulcers with dirty granulating bases and macerated overhanging walls. A large flattened lymph gland was palpable in either axilla. There was a suggestion of nuchal resistance, but no positive Kernig, clonus or Babinski. Reflexes showed normal bilateral response to stimuli. A clinical diagnosis of "Tularemia" was made.

Rectal temperature on admission was 105.4°F. and remained on a plateau throughout hospital stay to terminal 106.8°F. (rectal). Pulse varied inversely to temperature at times, ranging between 80 and 140. Respirations usually remained between 20 and 30 per minute.

Complete blood counts showed hemoglobin 90%, red blood cells 4,500,000, and white blood cells 15,000, with differential count of polymorphonuclears 66, lymphocytes, 30, monocytes 4.

Urinalyses: color, amber; reaction, acid; specific gravity 1.018 to 1.032; albumin, slight trace; no sugar, acetone or diacetic acid; no casts; occasional RBC or WBC; some uratic crystals.

Blood sugar was 106, blood urea nitrogen 22, blood creatinine 2.

Blood culture was negative on one occasion.

Blood Wasserman was negative. Serum agglutination tests performed by the Connecticut State Department of Health were negative for typhoid "O" and "H", paratyphoid "A" and "B" and Brucella infection (undulant fever); and positive tularemia as follows:

	Dilutions					
	20	40	80	160	320	640
Tularemia	0	+	+	2+	3+	3+

Chest x-rays showed evidence of pulmonary congestion.

On admission, patient was placed under strict infectious precautions. He was given 1 gm. of sulfathiazole every three hours the first night, then every four hours for total dosage of 24 gm. Diet was fluid throughout hospital stay.

Abdominal distention was treated by means of enemas, hypodermic prostigmine methylsulphate 1:2000 and rectal tube.

Bladder retention of urine was notable and persistent with relief by catheterization.

Restlessness was incompletely controlled by both opiates and barbiturates. Sodium amytal had to be administered in-



FIGURE 1
Ulcer on right hand



FIGURE 2
Caseous left axillary gland

travenously for control of patient sufficient to permit venolysis of normal saline solution with 5% glucose, to combat excessive dehydration. Herpes of the upper lip appeared on the fourteenth day of disease and was limited by application of the compound tincture of benzoin. At this time also a peculiar odor of typhoidal suggestion was noted about the patient.

On the sixteenth day of disease and the fourth of hospitalization the patient seemed to be improving. He was more quiet vocally and physically. Fever apparently losing its hold. Occasional response to orders was elicited. Nourishment was being taken. Eyes were still injected. Left pupil was slightly smaller than the right and neither reacted to light, though eyelids reacted to threatening motions. Herpes of lip was clearing. There was a slight body flush. Uleers of fingers were healing. Axillary adenopathy was stationary. Reflexes were normal.

The patient became verbose and restless during the night and died in the early morning.

Postmortem examination was accomplished by Clay S. Boswell, M.D., pathologist at the Veterans Administration Hospital, Newington, Connecticut, within 5 hours of death.

POSTMORTEM REPORT BY DOCTOR BOSWELL

"The body is that of a white, adult male, well developed and well nourished. Height 69"; weight, estimated, 180 lbs. There are no scars or marks of note other than three small ulcer like sores, one on each middle finger and another on the left forefinger. These are all on the distal phalanges and the two on the left forefinger and middle finger are kissing uleers. There are enlarged axillary glands, bilaterally, and there is also slight enlargement of the inguinal glands.

The upper part of the cord is normal in appearance.

The head and scalp are normal externally. The skull cap is of normal appearance and thickness. The meningeal vessels are gorged with blood and the surface of the brain appears somewhat inflamed and edematous. The basal vessels are congested but there is no evident pus. On section there are noted numerous small, petechial like spots. The ventricles are nor-

mal in appearance. There is a mild congestion of the choroid plexus.

On opening the abdomen the abdominal fat pad is of normal appearance. Muscles normal. There is no free fluid in the abdominal cavity. The diaphragm and abdominal organs are normal in position and size.

On opening the chest there are no adhesions noted. There is no free fluid in the pleural or pericardial cavities. There is apparent congestion of both lungs at the bases. The combined weight of the lungs is 1,400 grams. On cut section there is noted congestion of both bases. The heart appears grossly normal, weighs 430 grams. The pericardium and endocardium are smooth. The valves are grossly normal and the myocardium is firm. The pulmonary vessels and aorta are grossly negative. The esophagus is negative.

There are several carious teeth. The pharynx, larynx, and trachea are grossly negative.

There is a very small, white bleb, measuring 2 mm. in diameter, on the anterior surface of the liver. The liver weighs 2,150 grams. Spleen weighs 90 grams and is grossly normal. The pancreas and adrenals are grossly normal in appearance. The kidneys weigh 340 grams. Capsule strips readily. There is a normal ratio of cortex to medulla. The surface is smooth. The ureters and G. I. tract are grossly normal.

There are moderately enlarged lymph glands in both axillary spaces. These were removed and they are soft. On section these glands are both of a reddish, gray color and have several small areas of caseation in each node.

Diagnoses—

1. Tularemia, evidenced by bilateral digital ulcerations and bilateral axillary glandular infection.
2. Cerebral congestion.
3. Pulmonary congestion.

Microscopic Examinations

Specimen of lung shows a marked congestion and edema throughout.

Section of brain shows the smaller vessels greatly enlarged and engorged with blood. Surrounding the blood vessels there is a clear space, this apparently resulting from some edema. There is a mild proliferation of the gliafibrilles.

Section of the upper portion of the spinal cord shows greatly enlarged blood vessels.

Section of the pancreas shows no abnormality.

Section of the adrenal shows no abnormality.

Section of the kidney shows mild congestive changes. There is some cloudiness of the secreting epithelial linings of the tubules.

Section of spleen shows a mild degree of congestion.

Section of liver shows several very small areas of inflammatory round cell infiltration. On the surface of the liver section studied there is some homogeneous material which was apparently contained in the small bleb. There is no evidence of inflammatory reaction on the surface.

Section of lymph glands from the axillary regions shows a marked inflammatory reaction throughout the gland. The lymphoid follicles are practically all obliterated and there is some proliferation of the follicular cells. There are several areas of necrosis within the lymph glands. These are surrounded by lymphoid cells. There is no evidence of proliferation of plasma cells and no giant cells are noted."

DISCUSSION

This case is of interest particularly because it represent the first reported instance of tularemia in Connecticut. Previously, (including 1939), 12,296 human cases had been reported to the U. S. Public Health Service from 46 states of the United States and from the District of Columbia, besides those found in Alaska and Canada. Abroad the disease has been noted in Japan, Russia, Norway, Sweden, Austria, Czechoslovakia, Turkey and Germany.

Tularemia is also known as "Rabbit Fever," "Deer-Fly Fever" and "Plague-like Disease of Rodents." It is an infectious disease caused by *Bacterium tularense* and found in nature in a myriad of animal and insect hosts, over 20 of which have been proven sources of human infection, although over 90 per cent of cases have been traced to infected rabbits.

The presence of the disease was first intimated by McCoy in 1911 when he described a "plague-like disease of rodents" attacking California ground squirrels. The following year McCoy and Chapin isolated the causative *Bacterium tularense*, named such after Tulare County, California, the locale of the infected animals. In 1919 Francis identified this disease with "deer-fly fever" and proposed the designation "Tularemia."

Bacterium tularense is a small, pleomorphic organism, gram-negative, nonmotile and nonspore bear-

ing. It grows only under aerobic conditions. Growth is good on coagulated egg yolk and blood glucose-cystine agar, but not on ordinary laboratory media. Bacillary, coccoidal and bipolar forms are noted. A temperature of 56° to 58° C. kills the organism, although it has maintained life and virulence in glycerinated guinea pig spleen for 10 years at -14° C. Ordinary disinfectants are effective.

Methods of Transmission

The vector of the disease in rabbits has been noted to be predominantly the rabbit tick (*Haemaphysalis leporpalustris*). Other bloodsucking insects, such as lice, flies, other ticks and fleas, transmit interanimal infection. No natural infection has been reported in domestic rabbits.

Humans acquire the disease in the following ways:

1. Direct contact with infected animals—killing or handling.
2. Bite of insect vector.
3. Ingestion of undercooked infected meat.
4. Less usual contacts such as occur during animal and human necropsy, with animal bites and scratches, with tick-picking, with dressing chickens fed with rabbit meat and fish baited with rabbit meat, and with drinking infected water (Russia).

Sources of human infection have been rabbits (predominant), squirrels, flies and ticks (bite), cats, (bite or scratch), chickens, quail, opossum, pheasants, grouse, skunks, a hunting coat, dressing of primary lesion, laboratory work, tree squirrels, coyotes, dogs, hogs, groundhogs, muskrats, sage hens, deer, fox, bull snakes, raccoons, fish, water rats, eating insufficiently cooked rabbit meat and drinking infected water. Man to man transmission seems to be notably questionable.

Clinical types

Four clinical types of the disease have been differentiated as follows:

1. Ulcer glandular (87.5% of Foshay's 600 cases)—initial skin papule is followed by local ulceration accompanied by regional adenopathy.
2. Glandular (3%)—regional adenopathy with no primary lesion.
3. Oculoglandular (1.8%)—initial conjunctivitis is followed by regional adenopathy.
4. Typhoidal (7.7%)—sans primary lesion, sans regional adenopathy. This is the type of infection which affects laboratory workers by pass-

age through skin without causing primary lesion or regional adenopathy, but causing systemic disease with fever and prostration as outstanding features.

Symptoms

After an incubation period varying from several hours to 13 days, averaging about 3 days, onset of the disease is abrupt, with chills, fever, sweats, headache, malaise, vomiting and weakness. Prostration is notable. The primary papule, when present, is found during the first two days of the disease. It enlarges rapidly and then breaks down, leaving an ulcer with sharp margins and necrotic base. Regional lymph gland enlargement follows direct extension of the infection along lymph channels. Primary bacteremia is usually present for 7 to 10 days, disappearing as antibodies are developed, but leaving behind evidence of its effect in the form of focal necroses in the lungs, liver, spleen and lymph nodes. These areas may break down later into blood or lymph stream and result in terminal septicemia.

Temperature range generally falls between 102° and 104°F. for 2 to 4 weeks unless complications extend the period of illness.

A variable type of skin eruption may appear at any stage of illness.

Pulmonary involvement has been noted by x-ray in 90% of a series of cases, with 18% of these becoming sufficiently extensive to give clinical criteria of bronchitis, pleuritis, with or without effusion, bronchopneumonia and lobar pneumonia. Here the *Bacterium tularensis* may be found in the sputum or in the pleural effusion.

Following ingestion of the virulent organism, vomiting, abdominal pain and diarrhea come into the clinical picture.

Fatal meningitis has complicated the ulceroglandular chain of symptoms.

In over 10,000 American cases, gross mortality rate was 5.3%.

Diagnosis

The diagnosis of tularemia depends in great part on a "high index of suspicion." With the disease in mind it is generally easy enough to obtain a typical history, find the usual lesions and fit in the final diagnostic pieces of laboratory verification. Direct cultivation of bacteria laden material is difficult and impracticable. Even when blood culture is made early, the disease may have run its course by the time organism growth is noted and identification com-

pleted. More satisfactory is the subcutaneous or intraperitoneal injection into guinea pigs, rabbits or mice of material from the primary lesion or regional lymph nodes or pneumonic sputum or blood taken in the first week of the disease. The animal dies within a week when autopsy finds hemorrhagic edema at inoculation site, lymph node caseation and necrotic areas in spleen and liver. Appropriate smears stained with crystal violet show numerous organisms. Cultures of animal blood or liver or spleen particles on coagulated egg yolk or blood-glucose-cystine agar elicit growth in 3 days.

Blood agglutination tests are always positive, but not until the second week of disease, when a titer of 1:80 or over is diagnostic. Titers have reached 1:5000. Positive agglutination may be life long. Cross agglutination of *Brucella abortus* and *Brucella melitensis* is sometimes evident.

The opsonocytophagic reaction has been utilized for diagnosis, appearing also in the second week, and for differential diagnosis when cross agglutination is noted as above. Like agglutinins, opsonins last for years after recovery.

Two intradermal skin tests have been promulgated by Lee Foshay. One involves the use of a non commercially available bacterial suspension and the other utilizes commercially available immune serum controlled by normal serum from the same animal species. Reports so far indicate probable great utility of these tests in the early recognition of tularemia in that in most cases they become positive the first day of disease and remain so during the life of the patient.

Treatment

The keystone of the treatment of this disease is, as usual, good nursing, with all this term implies. The strength of the members of the therapeutic arch is as yet undetermined. Specific Foshay antiserum therapy was introduced in 1932 but has not yet been accepted for inclusion in the N. N. R. There seems to be a balance in favor of serum treated cases in the presence of complications, despite serum reactions (51%) and necessity for early administration (most effective the first 9 days of disease). Human specific immune serum has proved of no value. Wishful thinking in several recent reports has not shown any benefit definitely due to sulfonamide therapy.

In a final analysis therefore, our most effective weapon against this pestilence is prevention. Having

struck this State once, it can strike again. An adequate prophylactic program naturally starts with public health service observation and eradication of vectors of the disease as delineated above. The small game hunting public must be informed about this disease hazard by means of newspaper and radio publicity, especially as the hunting season starts. Rubber gloves should be worn by all handlers of small game carcasses until meat has been cooked. The gloves should be washed thoroughly with soap and water before removal. Boiling for ten minutes eliminates potential infection. The hunter should also remember that a rabbit not fit to hop is a rabbit not fit to eat.

SUMMARY

1. The first case of tularemia reported in the State of Connecticut is herewith presented together with autopsy findings.
2. Bilateral ulceroglandular type of disease was exhibited.
3. Course of disease was 2-humped, with remission followed by inexorable exacerbation.
4. Therapeutic use of 24 gm. of sulfathiazole was futile.
5. Tularemia is discussed.
6. Prophylaxis in the form of public health measures is recommended.

A case of tularemia treated with sulfanilamide is reported by Adolph W. Eckstein, M.D., in *The Rhode Island Medical Journal*, May 1941. (The Editor.)

New Journal On Medical Care

Somewhat belatedly an opportunity has come to review the first issue of the new periodical, "Medical Care." It is a quarterly devoted to the economic and social aspects of health service, a field that has received increasing and sometimes illogical consideration during the past few years.

The editor of "Medical Care" is Michael M. Davis who has had a long time interest in social medicine. Connecticut is represented on the Board by Professor C.-E. A. Winslow and Doctor John P. Peters. Others easily recognized are Doctor Claude Munger, Superintendent of St. Luke's Hospital, New York; George Soule of the New Republic; and Doctor Kingsley Roberts, the disciple of the coöperatives.

It is suspected that the enterprise is subsidized by

some interested and well meaning person, for it carries no advertising and its circulation will, at best, be small and highly selective. There may be a temptation to make a hasty first guess that this is another periodical of protest produced by a precious little group of thinkers who like to tell each other their own ideas of reformation. However the first issue belies that hunch as does the statement of editorial policy which is—

"To carry out our stated purpose, we wish to present experience rather than opinion, through articles, reviews of events and literature. We shall, however, also publish articles presenting diverse programs and proposals, as we do in this issue. It is important to deal with our subject roundly, because we expect our readers to include both professional and lay groups with varying backgrounds and ideas.

"We are especially interested in the facts concerning the organization, administration, economics, and social relations of medical services, and in the experience of plans for making good medical care more widely available. The views and interests of the professions that furnish medical care and of the people who receive it are equally to be considered."

The leading article, "The Progress of Nonprofit Hospital and Medical Insurance Plans in the State of New York," by Mr. Gardner, counsel of New York State Insurance Department, is illuminating to the degree that it states a lack of progress on the part of medical insurance plans. A cool and considered comment on Mr. Gardner's article by a Committee from the Medical Society of the State of New York is added. There is a paper on tuberculosis case finding among Negroes and a report of a symposium on "Local Initiative for Organized Medical Care," telling the experience of unions in Chicago.

On the whole, "Medical Care" has a calmly presented, more or less valuable discussion of subjects in the field of distribution of medical care. It can fill a place that has been left vacant in periodical medical literature, and its future issues will be awaited with interest.

Reduced Insurance Rate

The Physicians Casualty Association of America has made a reduction in the \$25.00 per week accident and health insurance, of \$1.00 per year; in the \$50.00 per week accident and health insurance, of \$2.00 per year and in the \$75.00 per week accident and health insurance, of \$3.00 per year.

PSYCHIATRIC CONTRAINDICATIONS TO MARRIAGE

EUGEN KAHN, M.D., *New Haven*

The Author, M.D. *University Munich 1911, Hon. M.A. Yale 1930. Sterling Professor of Psychiatry and Mental Hygiene, Yale University School of Medicine and Psychiatrist-in-chief New Haven Hospital and Dispensary 1930*

A CONSIDERABLE amount of misery that is essentially due to mismated marriages is encountered by the medical profession.

Our advice as regards marital problems is, in most instances, sought only when a marriage is going or threatens to go on the rocks. In the majority of cases in which we are consulted before the marriage is concluded, the people have already made up their minds, and if they have decided against marrying, they come to us in order to procure a face-saving device. Now and then we are confronted with a situation in which a physician, in full recognition of a patient's mental difficulties, unfortunately had more or less urged him or her to marry, predicting that marriage would straighten out the difficulties.

The manner of adjusting in and to our social order is an indicator of the maturing process of the personality. Adjustment is a difficult task for many individuals even if they have to think and to take care of nobody but themselves. It becomes still more difficult, it becomes indeed ever so often an entirely insoluble problem, if such people marry and thus commit themselves to greater and broader responsibilities. A successful, happy marriage appears to be the highest form of personal adjustment of adult, mature people who have grown out of the original attachment that had tied them to their parents or to parent-substitutes. It should be said, though, that there are unmarried adults who achieve excellent adjustments. An unsuccessful, unhappy marriage is not only *per se* a deplorable state of maladjustment, but is bound to lead to all kinds of suffering, and this, as a rule, for more than two people.

It is quite evident that, with all our primary interest in advising and aiding the person who desires our advice and help, we cannot allow ourselves to consider this individual exclusively, but have to give thought to his own family, to his prospective mate, and to the potential progeny. It is not just the present state of health of the individual we have to adjudge,

but his whole personality, and his attitudes towards life and people and the community. To this we have to add our knowledge of the personalities and attitudes in both families, e.g., an adolescent girl wants to marry the hero of her dreams, himself probably not a too well balanced person. We have naturally the gravest doubts in respect to the outcome of such a union, and our doubts will increase if the families show themselves hostile and decline any moral, social and economic support. The formulation of our advice may take on another color if the families are friendly, understanding and ready to help.

We should always bear in mind that our task is to give counsel, not to permit or to forbid. We should never try to play the Great Lord, the less so as our prognostications may fail; they are based on probabilities anyway. We have to give our opinion and advice as objectively as possible in a formulation which includes a clear explanation of the whole situation. For instance, a schizophrenic patient and his relatives would be ill satisfied would we bluntly say that he ought not to marry because he is schizophrenic. We must rather, after thorough examination and investigation, explain how and why the patient's difficulties keep him from attaining a good adjustment, and how and why matrimony, with its social, psychological and physical obligations, would intensify, even multiply, his own difficulties, and beyond this produce any number of difficulties in the life of his intended mate and the children, if there should be any. Every case and every situation is unique, and our clinical label diagnoses, helpful as they are, do not in themselves present any solution; but we have to use them in this brief discussion as a compass, so to speak. We should not be surprised and not take offence when once in a while our best considered advice is not heeded. After all, the premises under which we think and work are profoundly different from the emotional bias and the wishful thinking of people who are or believe themselves to be in love.

It is not necessary to go into details as regards the large and rather motley group of chronic organic psychoses with poor or bad prognoses. It is absolutely undesirable, of course, that patients suffering from such disorders marry.

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On the other hand, we find many acute mental disturbances accompanying other diseases which in themselves cannot be considered as contraindicated to marriage. We must naturally be sure that the acute disturbance is not part of a chronic mental disorder.

About the feeble-minded we have to say the same as we did about the chronic organic psychoses, regardless of whether the handicap is a constitutional or an exogenous one. Feeble-minded persons, in our opinion, should never marry.

We should mention that the statutory law of Connecticut decrees:

Section 6275—Every man or woman either of whom is epileptic, imbecile or feeble-minded who shall intermarry, or live together as husband and wife, when the woman is under 45 years of age, shall be imprisoned not more than three years.

furthermore:

Section 6276—Any person who shall advise, aid, abet, cause or assist in procuring the marriage of any person in violation of the provisions of Section 6275, knowing such a person to be epileptic, imbecile or feeble-minded, shall be fined not more than one thousand dollars or imprisoned not more than five years or both.

The implication of the provision "when the woman is under 45 years of age" is clear.

While our attitude toward the feeble-minded is definitely more strict than that of the law-giver, we consider the situation in respect to the epileptic, that is to the convulsive disorders, as less simple than he apparently does. For patients who are overtly epileptic already during childhood and adolescence, we deem marriage entirely inadvisable. If, however, the convulsive disorder starts later, and if the epileptic manifestations are rare, can be kept under control therapeutically, and do not lead to a disintegration of the personality, we may, if circumstances are also otherwise favorable, not in all cases be averse to marriage as a number of such patients are capable of leading a fairly well adjusted life.

In respect to the schizophrenics, marriage is definitely contra-advised in all those patients in whom the downhill course of the disorder can already be observed or predicted with fair certainty. There are, however, a number of patients whose schizophrenic disorder is more or less episodic and does not effect the destruction of the personality. For them matrimony may not always be strictly

contraindicated if the situation as a whole is propitious.

A particular scrutiny is in order in respect to patients who actually or occasionally suffer from affective disorders—depressions, manic conditions, manic depressive psychoses. There are many such patients in whom these disturbances occur in a relatively slight degree and are of short duration. Such patients are ordinarily capable of successful adjustments for themselves and their families. There are, however, other patients whose days of illness by far outnumber their days of health and who, even in their relatively healthy times, have such outspoken tendencies toward gloominess or exaggerated exhilaration or emotional imbalance that they have a hard job to keep themselves somehow socially afloat and scarcely enough reserves to take care of a family of their own.

There are certain unbalanced people with all sorts of shortcomings in their impulse life, particularly as regards sex, in their temperamental endowment and character development—we call them psychopathic personalities—whose failing in matrimony can be predicted with the highest probability. It is noteworthy that psychopathic personalities frequently intermarry. Among psychopathic couples occur very frequently the most complicated marital maladjustments, making the lives of their children, who usually are psychopathic also, very miserable. Among psychopathic personalities are found most of those patients who present features of those ailments that are essentially psychologically conditioned; in some quarters these disturbances are labelled neuroses and psychoneuroses. To the psychopathic personalities belong the majority of the chronic alcoholics and drug addicts. Although we are generally not in favor of seeing outspokenly psychopathic personalities marry, we must look most thoroughly into the assets and liabilities of every single case. We have to be mindful of the fact that there are among these psychopathic personalities a goodly number of highly intelligent and socially valuable persons whose efficiency and achievement can definitely be augmented through the skillful care and coöperation of a really understanding, devoted wife or husband—not without sacrifices on the partner's side, but the partner may deem it worthwhile to make sacrifices. He often has more or less to play a parental role for his psychopathic mate.

So far our discussion has been concerned only with patients. Now and then we are consulted by

persons who are themselves healthy and well adjusted, but wonder whether they might marry because there are mental patients in their families. Without being skeptical about their own mental health, they may be apprehensive as to their possible offspring. In the causation of most of the disturbances we have enumerated, constitutional factors play a very important role, and we have some notions as regards the hereditary danger threatening members of tainted families. But only the most intensive study of the family trees will permit us to formulate an opinion, and this opinion is always based only on probability. Hence, after giving a survey of all possibilities and probabilities, we will in general not be able to say more than this: "Such and such are the risks you are going to take for yourself and the children you may have; here are your assets and here are liabilities you may not want to overlook." It is understood that in such, as in every other case, the intended mate should be informed of our opinion.

With all our endeavor to give a few leads, we want to stress once more that in every case we have to start anew with another person and another situation. Assets which in one case may be almost negligible may, in another constellation, be quite important, and liabilities which may appear relevant here may not be significant there. We could well be less over-cautious in our considerations and formulations if it were not our duty to consider the unborn children, or, to put it differently, if we were permitted to give contraceptive advice. This, however, is deplorably still against the law in Connecticut.

Notwithstanding the law, I feel free to summarize as follows:

Whereas marriage is never and should never be considered a therapeutic tool, not to marry is the most powerful measure of preventive psychiatry.

THE 1941 CLINICAL CONGRESS

(Continued from page 644)

library to medical progress and practice. Refreshments will be served by the Committee on the Clinical Congress in Beaumont Room.

One of the main features of this present Congress is the inauguration of the special course in traumatic surgery organized by Doctor S. C. Harvey. This course, which is broad in its scope and of eminently practical value, will start on the first day of the Con-

gress and will continue weekly after the Congress throughout the winter. It is especially designed to train physicians in the management of highway and other accidents and also to acquaint them with the important details concerned in disaster relief.

In reviewing, therefore, this extensive program it would seem that it would be difficult for any physician of our State not to avail himself of these great opportunities.

Annual Report Shows Progress In Campaign to Protect Eyes

Special vigilance to protect eyesight is needed at the present time because of greater accident hazards resulting from the expansion and speed-up of industrial production for national defense, according to the Annual Report of the National Society for the Prevention of Blindness, recently made public.

Advances have been made on many fronts in the war on blindness, the report points out. At the present time, the Society is engaged in public education concerning glaucoma, a condition which confronts thousands of men and women as they grow older. "Through early recognition of glaucoma," the report states, "much blindness from this cause might be averted. We must impress upon the general public the importance of periodic eye examinations by a competent physician who, through training, is able to recognize the subtlest eye symptoms." The Society is also participating in the fight against syphilis and gonorrhea.

IONTOPHORESIS WITH ZINC PEROXIDE

(Continued from page 664)

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15. Perry, C. C. Zinc peroxide in infected wounds. *J. Florida Med. Ann.* 26. 453-455. 1940.
16. Shallow, T. A., Foy, K. E., and Pulaski, E. J. *Surg. Gyn. Obst.* 70. 987-995. 1940.

UNUSUAL CASE OF HODGKIN'S DISEASE

WILLIAM FINKELSTEIN, M.D., *Waterbury*

The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the JOURNAL. The following from St. Mary's Hospital, Waterbury, is the eighth in this series. (The Editor.)

The following case is being reported because of the many interesting points it presents.

Mrs. M. M., a 62 year old married white female, was admitted to St. Mary's Hospital, Waterbury, with the chief complaint of weakness of several years duration. The past history revealed that 16 years previously, at the age of 46, she began to complain of weakness, a left flank pain, and loss of weight. Two years later, i.e., 14 years ago, a left tuberculous kidney was removed. Two years following this operation, i.e., 12 years ago, a left tuberculous ureter was removed because of the persistent presence of a discharging sinus in the left flank. The local symptoms disappeared but the patient continued to complain of weakness, fatigue, and pallor. Physical examination revealed the blood count to be as follows: Hgb. 61%; R.B.C. 3,500,000, and W.B.C. 5600 with 73% polys and 27% lymphocytes. The smear showed moderate achromia. The spleen was enlarged down to the umbilicus. Transfusions were only a temporary value as far as the anemia was concerned, but the splenomegaly promptly disappeared with x-ray therapy only to return again after varying intervals. However, it continued to be responsive to repeated doses of x-rays until the very end.

Fragility studies were never done but a Congo red test for amyloid disease was negative. In view of the long duration of the anemia with a relatively low white count in the presence of splenomegaly without other physical findings the diagnosis of Banti's disease was made, even though the splenomegaly continued to be very responsive to x-ray radiation.

Final admission was in January 1941 when in addition to her anemia she presented signs of cardiac insufficiency such as cough, dyspnea, substernal oppression, and ankle edema. Physical examination at this time revealed cyanosis of the lips, tachypnea, bilateral dulness over both lung bases posteriorly with coarse rales, rapid irregular heart with double murmurs at both the apex and the base, moderate peripheral arteriosclerosis, a liver three fingers below the costal margin and a spleen four fingers below the costal margin with a firm irregular lobulated edge.

Blood count was as before. The patient expired the day following admission.

The autopsy revealed the following interesting findings:

Heart—considerable hypertrophy of the left ventricle. Moderate sclerosis of the coronary vessels. Marked distortion of the aortic valves by deposition of calcified material into the valve rings and cusps with a resulting extreme degree of stenosis.

Lungs—bilateral congestion.

Liver—enlarged to 2200 grams.

Spleen—enlarged to 750 grams. Microscopic examination of the spleen revealed a most unexpected picture. The splenic pulp showed evidence of fibrosis with infiltration by all types of wandering cells among which large mononuclear cells predominated. In the pulp were numerous large giant cells, some of which were multinuclear while others had lobulated nuclei. Many of these conformed accurately to the giant cell described by Reed and Sternberg. Similar cells were found in the liver but in no other organ, and lymph node involvement was nowhere found.

Anatomical Diagnosis: Hodgkin's disease of the spleen and liver. Generalized arteriosclerosis. Calcareous aortic stenosis.

There are several features in this case worthy of attention. In the first place, the splenomegalic form of Hodgkin's disease, which differs from the more common larval form in the absence of fever, is very rare. Even in large series of cases it is hardly found, whereas splenomegaly in the presence of associated lymph node involvement is common (60-65% of Boyd's series in his Pathology of Internal Diseases). Its differentiation from splenic anemia or Banti's disease is extremely difficult (Longcope in Cecil's Textbook of Medicine).

Secondly, the long duration of at least 14 years is remarkable. Scattered through the literature are occasional reports of cases lasting 5, 10, and even 15 years, but the usual case has a much shorter duration. Thus Craver (Am. J. Med. Sci. 188:609; Nov. 1934) in a series of 125 cases found 12% only to

have a survival period of 5 years or more, while Goldman (J. A. M. A. 114:1611; Apr. 27, 1940) in a series of 123 cases found an average survival from the time the patients came under observation of 32.06 months and from the institution of radiation therapy of 23.8 months. Eleven patients (10%) had a five year survival period with 2½ months the shortest period of survival and eleven years the longest.

Finally, the association of Hodgkin's disease and tuberculosis in the same patient brings up the possible etiologic connection of the two conditions. Formerly, it was commonly held that there was a definite connection. Thus Sternberg in 1898 wrote that Hodgkin's disease was a form of tuberculosis. Frunkel and Munch believed they found a form of the tubercle bacillus in Hodgkin's disease. However, at the present time, it seems to be the consensus of opinion that while finding typical tuberculous changes in lymph nodes side by side with Hodgkin's process is not uncommon yet the bulk of evidence is against any cause and effect relationship. In fact, at the present time, much more attention is being paid to the possible etiologic relation of undulant fever to Hodgkin's disease (Wise and Poston J. A. M. A. 115:1976; Dec. 7, 1940). Whether this relationship proves to be a more substantial one than that between tuberculosis and Hodgkin's disease remains to be determined.

New Grants for Infantile Paralysis

The National Foundation for Infantile Paralysis announces the distribution of new grants totaling \$195,030 with which to carry on its battle to conquer infantile paralysis. Among the new grants listed for New England are two totaling \$6,300 to the Children's Hospital, Boston, for the continuation of a study aimed at determining the effects of infantile paralysis on the growth of lower extremities and the inauguration of a study of the effect of prolonged periods of bed rest and other factors in the development of calculi or stones in the urinary tract of infantile paralysis patients. There is also a grant

of \$2,500 to the Massachusetts General Hospital for a continuation of a study of clinical cases where patients have an unequal growth of lower extremities, and a grant of \$3,000 to the Boston City Hospital for a study of the gastrointestinal tract as a portal of entry of the virus in paralysis.

Sulfaguanidine, New Sulfonamide Derivative, Is Released by Squibb

Sulfaguanidine, the new sulfonamide compound which clinical trial indicates may be of great usefulness in certain diseases of the gastro-intestinal tract, has been released for sale by E. R. Squibb & Sons, New York. It is supplied in 0.5 gram tablets, in bottles of 50, 100 and 1,000, and as a powder in 4-ounce and one-pound bottles; also in 3.5 gram envelopes in packages of 12.

Sulfaguanidine is distinguished from other sulfonamide derivatives by its low absorbability. This causes it to remain in the intestinal tract and exert its anti-bacterial influence therein. Consequently, it is useful in enteric infections, such as acute bacillary dysentery, and also as a preoperative and postoperative measure in surgery of the lower intestinal tract.

Like the other sulfonamides, Sulfaguanidine has high anti-bacterial activity. Unlike them, and in spite of its relative solubility in water, it diffuses to a much less extent through the intestinal wall. It is, therefore, possible to obtain a relatively high effective concentration of the drug in the intestine itself (200 mg. per cent) with little penetration into the circulation and consequent systemic effects (1 to 4 mg. per cent concentration in the blood).

A tasteless drug, Sulfaguanidine is administered either in tablet form or as powder in water or similar medium. Recently 5,000 tablets of this newly discovered drug compound was sent to China by the China Clipper to check the spread of dysentery in the Chinese armies. According to reports from China, dysentery is the most widespread sickness in the army, accounting for more sick casualties than any other cause.

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THE NEW YALE MEDICAL LIBRARY

HERBERT THOMS, M.D., *New Haven*

CONCEIVED IN A spirit of service, not only to the Medical School and University but to the community and the State, the new medical library at Yale, which was dedicated on June 15 of this year, is destined to become an important influence in the lives of the physicians of Connecticut. This notable addition to the Medical School buildings, made possible by a grant from the trustees of the Sterling funds, will provide space for more than 400,000 volumes in addition to many special collections. It will also make possible the centralization of practically all medical books, periodicals and journal files which, because of lack of suitable space, have previously been housed in other parts of the University. In addition to making its holdings available to the medical community at large the library is destined to serve, in many respects, as an Academy of Medicine for the medical community of our State. Rooms are to be made available for special evening meetings and separate small rooms and alcoves can be set aside for the use of physicians who wish to study the literature of a special subject. Ultimately it is hoped that bibliographical service can be extended in tracing the literature of a special disease or field of study.

Immediately comes to mind the useful and important service which the library can render in problems arising out of the present emergency. For those whose concern is medical defense, base hospital equipment or other aspects of military medicine many of the latest publications on these subjects, both American and foreign, are available. Very recently the library has brought together its holdings on medical problems during the last war and upon the history of military medicine in general. This collection is at present on reserve shelves in order that it be of the greatest possible usefulness. Included in it are all the recent publications from Army, Navy and Public Health Services of the Government, as well as documents issued by The Committee on Medical Preparedness of The American Medical Association.

The new medical library is divided both by structure and by its organization into two sublibraries; a division concerned with the history of medicine and the sciences known as the Historical Library, and a division concerned with modern medicine design-

nated the General Medical Library. Located between these two libraries is the large periodical room, the Beaumont Room and the Exhibition Rotunda, the latter being a memorial to the late Harvey Cushing and presented to the University by the class of 1891, Yale College, of which Doctor Cushing was a member.

THE HISTORICAL LIBRARY

The Historical Library building came into existence largely as the result of the influence and benefaction of Doctor Cushing. Several years ago he made it known that he intended to bequeath his extensive and valuable personal library to Yale University if suitable accommodations could be arranged to house the collection. He had in mind a general structure consisting of two wings which should be equally accessible and insisted that their location should be such that the physician should not have to climb steps in order to enter. In his words, one should be able to "fall into the library without developing hyperpnea, cyanosis, or the effort syndrome." With this stipulation in mind his classmate, Mr. Grosvenor Atterbury, architect developed a Y-shaped plan, the stem of the Y being set aside for accessory library service, photography, cataloging and other technical procedures. The two arms of this plan comprise the space devoted to the Historical and General Libraries, respectively.

In the Historical Library is housed the Cushing Collection comprising the principal works, generally in earliest editions, of all the great masters in surgery. Among these are found such names as Andreas Vesalius, William Harvey, Ambroise Paré, John and William Hunter and lesser authors, as Culpeper, Garth, Mead and many others. In recent years Doctor Cushing had been impressed with the close interrelation between the history of the sciences (biological and physical) and the history of medicine, and to this end he had acquired many of the great books representing landmarks in the history of physics, chemistry and the physical sciences. This entire library of approximately 15,000 volumes, together with his personal diaries, notebooks and vast files of correspondence may be said to form the nucleus of the Historical Library.

Another notable collection which will one day come to Yale is that of Doctor Arnold C. Klebs, a

THE HISTORICAL LIBRARY



THIS IS REPRODUCED THROUGH THE COURTESY OF THE YALE JOURNAL OF BIOLOGY AND MEDICINE

lifelong friend of Doctor Cushing, now living in Switzerland. Doctor Klebs, probably the foremost living authority on the medicine of the fifteenth century, the incunabula, will transfer this important collection to America as soon as world conditions permit. Added to these two famous collections is the equally important collection of Doctor John F. Fulton, Sterling Professor of Physiology at Yale. This collection embraces works principally in the fields of physiology and experimental medicine. Particularly represented are the works of Robert Boyle, Sir Thomas Browne, Sir Kenelm Digby, Joseph Priestley and Thomas Willis. Important collections which are also housed in the library are the Edward C. Streeter collection of weights and measures and items from early pharmacies, the Clements C. Fry collection of books and prints representing the history of psychiatry, the Jonathan Knight collection and the Beaumont collection of memorabilia relating to William Beaumont and Connecticut medicine. Other significant collections are those of Doctor George M. Smith, Doctor George Blumer and Doctor J. G. Dusser de Barenne.

The Historical Library is destined to become a real laboratory for historical research, for it was definitely planned to be other than a rare-book room for the exhibition of literary treasures. Productive scholarship will be fostered by the use of all the available tools for historical and bibliographical research. To this end included in the plans were eight small rooms and numerous alcoves which physicians, medical students and others engaged in historical quests will find available for their service.

THE GENERAL MEDICAL LIBRARY

The wing which houses the general medical library is a broad, well-lighted two story room with wide balcony to enhance floor space, and makes available on open shelves the most recent monographs and textbooks grouped in accordance with the preclinical and clinical subjects, such as anatomy, pharmacology, pathology, neurology, general medicine, physiological chemistry, bacteriology, pediatrics, surgery, etc. Current volumes of the journals devoted to these special subjects are also available on the open shelves of the room. The periodical room may be entered directly from the General Medical Library so that immediate access may be had to recent unbound numbers of current periodicals. As in the Historical Library, here too are alcoves with convenient tables where seclusion for extended work is available.

Such in brief outline is the new Medical Library at Yale. It represents one more expression of the ideal of service which a great university may render. All workers in the fields of medical science may therefore be congratulated upon the completion of these fine buildings which are to be devoted to their service. The buildings are completed but the libraries which, properly speaking, are inside these physical plants of course can never be finished. It remains the privilege of all who can benefit from these fine opportunities to add to these great collections and to support the generous aims for which this institution was built.

The Adopted Child

They must tell the child early and often, always with pleasurable connotations, that he is adopted; they must be prepared to comprehend with tolerance the child's outbursts of hostility and his various perverse and anti-social acts, realizing that all normal children exhibit these things; they must never express to the child in any way feelings of regret that they adopted him or attribute his misbehavior to his not being their own child; and they must even avoid thinking within themselves that his behavior is alien and attributable to inheritance. Forewarned in these respects, possessed of a natural tolerance and affection for children, there is no reason why foster parents may not successfully rear a child who is not their own.

Bull. Menninger Clin., May 1941.

Vitamin C and the Therapeutic Metals

Ruskin and Sieberstein (*Medical Record*, May 7, 1941) report a series of cases to prove the following conclusions:

1. Vitamin C assumes a new importance as a molecular vehicle for the therapeutic metals of bismuth, antimony and arsenic.
2. The therapeutic index of bismuth cevitamate is substantially higher than that of a series of commonly used bismuth preparations.
3. The increased chemotherapeutic index is clinically demonstrated by the effectiveness of bismuth cevitamate in a series of Wasserman-fast cases.
4. Further study on the use of vitamins as molecular radicals, for combination with therapeutic metals, offers an interesting avenue for investigation.

CONNECTICUT STATE MEDICAL JOURNAL

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month—day of month if weekly—and year.

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NEWS: Our readers are requested to send in items of news, also marked copies of newspapers containing matter of interest to physi-

cians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS: All advertisements are subject to the approval of the Council on Pharmacy and Chemistry of the American Medical Association and should reach the Editor by the tenth of the month preceding publication.

SUBSCRIPTIONS: Membership in the Connecticut State Medical Society includes subscription to the Journal. Additional copies may be secured from the Editor.

REPRINTS: Reprints of papers and obituaries may be obtained from the Editor at cost.

EDITORIALS

The Line Forms On the Left

On the morning of September 16 Yale University will again open its doors to the members of the Connecticut Clinical Congress. Coming each year just prior to the opening of the University activities this event also marks the beginning of a sort of fiscal year for the Connecticut doctor. Vacation days and summer heat have been dissipated, forgive the word, but the present season is twice blest for the return of the oyster is also accompanied by our finest fall weather. The time has come for the doctor to roll down his sleeves and fold away his white flannels, for now he proposes to think more seriously of his task. So mid September finds him again in New Haven preparing to take a pleasant, if heroic dose of postgraduate medicine. And massive the dose really is, but so adroitly divided and so highly concentrated by the Program Committee that its tonic effects are both immediate and lasting.

The Connecticut Doctor has a right to be proud of his Clinical Congress for its success and reputation have extended far beyond the bounds of his little "land of steady habits." Evidence of this is

quite at hand, for other assemblies of a similar nature in various parts of our country have studied carefully this pioneering Connecticut enterprise. A remarkable thing about this yearly "brush-up" is its continued and growing vitality. Each year has seen surprising and ingenious innovations some of which have been frankly experimental, in itself a sign of healthy growth. A survey of this year's program proves no exception. In addition to the more formal part of the program the new Yale Medical Library will welcome our members to view its treasures and become familiar with the many opportunities which have been developed for their service. The opening of this great medical library is truly an event of moment for the physician of Connecticut. However, in addition to our deep gratitude for these privileges comes to each of us also a sincere sense of obligation. We in turn can serve this great library which will serve us, for ours is the opportunity to support its plans for development and to add to its collections.

Elsewhere in this issue appears the complete program of the 1941 Clinical Congress. Study reveals that the Program Committee has carefully chosen

for discussion those topics which are of more than ordinary interest. Our sincere congratulations go to this group of our members for their excellent judgment and sincere devotion to an important duty.

Judging from past experience the line forming at the left of the registration desk on the 16th will be a lengthy one. You will save yourself a good deal of time and fumbling by registering right now! Many wise ones have already done so.

The National Physicians Committee in 1941

Following the verdict of guilty of "a criminal conspiracy to restrain trade" handed down by a Federal Jury in Washington on April 4, the National Physicians Committee issued a statement which should be of interest to all physicians. It calls attention to the fact that, as far as the settlement of the issues is concerned, the verdict is without sense or substance or meaning. Certain basic principles, which in their establishment involved no legal authority, have been challenged. To relinquish them would mean that laymen and lay organizations would have a legal right to provide medical service, that qualified doctors of medicine could no longer determine or influence the qualifications of hospital staffs and courtesy privilege physicians, and that doctors of medicine would be denied the right to determine or importantly influence the educational standards for medical students, and the nature and quality of intern training. Should this come to pass the quality and standards of medical service would be placed in jeopardy and we shall then have an army of quacks competing in the open market for the patronage of the ailing and the sick.

The public must be informed and be made aware of its vital interest in this all important issue. To this latter task the National Physicians Committee has set itself. Through the medium of a series of full newspaper pages from coast to coast and through a weekly editorial service to more than 12,000 weekly and foreign language newspapers in the United States, information has been disseminated to the public. Both Mr. Willkie and President Roosevelt in 1940 expressed opposition to the socializing of medical practice.

The war clouds are gathering rapidly. American Medicine has been called upon to aid in National defense by manning the Selective Service Medical boards, by supplying physicians to the Army, the Navy, and the Air Corps. In addition, Britain has

called upon us for 1,000 physicians to help fill gaps in their defense program. American medicine is faced with the possibility of drastic changes in its structure. We must not permit the quality of medical service to suffer. The National Physicians Committee has set itself the task of securing public approval of the standards set up by American Medicine and endorsement of only those changes which shall eventuate in improved medical care. The accomplishment of this purpose necessitates the understanding, the coöperation, and the financial support of every county medical society and of the rank and file of the profession.

E. Kent Hubbard

In the death of E. Kent Hubbard, President of the Manufacturers Association of Connecticut, industrial health in Connecticut has lost its foremost friend.

As a member of the State Board of Finance Mr. Hubbard in 1928 was instrumental in the founding of the Bureau of Industrial Hygiene of the State Department of Health.

Concerning the joint program of the Manufacturers Association of Connecticut and the Connecticut State Medical Society for the protection of defense workers which he staunchly supported, Mr. Hubbard recently said, "A program of this nature can not follow any hard and fast lines. It can but seek to stimulate close analysis of existing and potential industrial health problems, and urge that every practical protection against the hazard of industrial society be maintained and strengthened. In the extension and improvement of industrial medical service there is both opportunity and obligation."

Governor Appoints Board of Examiners in Physical Therapy

Acting under authority granted in a law passed by the 1941 General Assembly Governor Hurley has announced the appointment of the State Board of Examiners of Physical Therapy Technicians. Doctor Joseph A. Beauchemin, Connecticut State Hospital, Middletown, one year; Doctor John F. O'Connell, Hartford, two years; Doctor Carl J. Gade, Bridgeport, three years; Doctor Charles Edlin, Waterbury, four years; Doctor Denis S. O'Connor, New Haven, five years.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

NEW HAVEN

COMMITTEE ON PREPAID MEDICAL SERVICE

The reorganized Committee on Prepaid Medical Service held its first meeting on Sunday, August 3, at the residence of Doctor Samuel C. Harvey in Madison.

There were present the Chairman of the Committee, Doctor Stringfield; Doctor Harvey; Doctor Miller; Doctor Murdock; Doctor Pitock; Doctor Whipple; the Executive Secretary.

Doctor Norman M. Scott, the Medical Director of Medical Service Administration of New Jersey was the guest of the Committee. Doctor Scott explained at some length the developments that had taken place in New Jersey, and the procedures that had been followed by the Medical Society of New Jersey. It was interesting to note the similarity between the pattern and procedure of New Jersey and that that has been experienced by this Society. New Jersey is further along than Connecticut, but the avenues of approach have been almost identical.

The Chairman asked for an expression of opinion concerning the future objectives of the Committee on Prepaid Medical Service and an outline for its future action is being prepared by the Executive Secretary for approval by members of the Committee. It is probable that the Committee will present definite recommendations to the House of Delegates at the winter meeting in December.

Physicians Licensed to Practice in Connecticut

The Connecticut Medical Examining Board has announced that the following physicians are licensed to practice medicine in Connecticut as a result of the written and oral examinations given by the Board on July 8, 9, and 22, 1941.

LICENSED BY WRITTEN EXAMINATION

John O. F. Nolan	Hartford
Gerald V. Mitchell	Winsted
David A. Grendon	New York
Percy L. Smith	Hartford
Marie S. Lindsay	Middletown
Charles H. Pitegoff	New Haven
Colman Lopatin	New Haven
Jerome A. Covey	Bridgeport
Helen M. Wallace	Valhalla, N. Y.
Harry Gershman	Hartford
William Metcalf	New Haven
Reubin I. H. Solway	New Haven
Martling B. Jones	Norwalk
Carmin J. Coppeto	Waterbury
Branch Craige	New Haven
John D. Prior	Hartford
Rowe A. Castagno	Hartford
Stewart P. Seigle	West Hartford

Saul J. Jaiven	Stamford
Sidney L. Cramer	New York, N. Y.
John J. D. Ryan	Stamford
Kurt Oppenheimer	Norwich
C. Perry Cleaver	Greenwich
Vincent M. Iovine	New York, N. Y.
Warren W. LaPierre	Norwich
Gert M. K. Wallach	New Canaan
William E. Swift	Cornwall
William Lee	Hartford
Robert W. Shreve	Hartford
Rector T. Davol	Greenwich
Hugh Tatlock	New Haven
Massimo Calabresi	New Haven
Sidney A. Chait	Middletown
Grover A. Lyon	Bridgeport
Felix R. Morris	Bridgeport

LICENSED ON THE BASIS OF CREDENTIALS

Richard R. Barber	Glenbrook	N.B.M.
Preston N. Barton	Hartford	N.B.M.
Casimer Bielecki	Norwich	N.B.M.
W. Turner Carstarphen	Westport	N. Car.
B. Poland Cunningham	Rochester, Minn.	N.B.M.
Thaddeus Danowski	Derby	N.B.M.
Guido A. DeBlasio	New Haven	N.B.M.
Flanders Dunbar	Kent	N.B.M.
Edward Finesilver	Newark, N. J.	N.B.M.

James Flett, Jr.	New Haven	N.B.M.
Peter P. Gudas	Malden, Mass.	N.B.M.
Lester S. King	Newton	N.B.M.
Milton M. Lieberthal	Bridgeport	N.B.M.
Louis A. Lobes	Milford	Tenn.
Edward Martin	New Britain	N.B.M.
Marvin Mogil	New Haven	N.B.M.
Woodbridge E. Morris	New York, N. Y.	Md.
Samuel Nesbitt	New Haven	N.B.M.
Thomas G. Peacock	Hartford	Ohio
V. Gerard Ryan	Portland	N.B.M.
Saul Thomases	Milford	N.B.M.
Lester J. Wallman	Stamford	N.B.M.
Luther A. Weigle	Hartford	N.B.M.
Fred Zaff	New Haven	Mich.

Speakers' Bureau

Doctor Arthur H. Jackson, Chairman of the Sub-Committee on the Speakers' Bureau, of the Society's Committee on Public Relations, announces that the members of the Society will be available for addresses to lay audiences and organizations during the coming winter as follows:

- CANCER
- Charles L. Larkin, Ashley W. Oughterson,
Edward J. Ottenheimer
- GENERAL MEDICINE AND GERIATRICS
- Clarence L. Robbins, Peter J. Steincrohn
- CHILD WELFARE
- Martha L. Clifford, Louis Spekter
- INDUSTRIAL MEDICINE
- Clifford Kuh, Andrew J. Jackson, Charles F. Yeager
- MEDICAL HISTORY
- John F. Fulton*
- MEDICAL CARE AND HOSPITALIZATION
- Albert W. Buck*
- NATIONAL DEFENSE
- John F. Fulton,* Donald B. Wells
- PEDIATRICS
- J. Harold Root, Grover F. Powers, Oliver L. Stringfield
- PSYCHIATRIC AND EMOTIONAL PROBLEMS
- Arthur H. Jackson, Clifford D. Moore, William B. Terhune
- SOCIAL MEDICINE
- Creighton Barker, Samuel C. Harvey, James R. Miller, Stanley B. Weld

TUBERCULOSIS

Cole B. Gibson, Joseph I. Linde, David R. Lyman,
Paul S. Phelps

*Non members.

Connecticut State Committee of the American Society for the Control of Cancer, Inc.

The first annual meeting of the Connecticut State Committee of the American Society for the Control of Cancer was held in Waterbury on June 25. Doctor Charles L. Larkin, president, presided and the following trustees were present:

- Doctor Donald M. Beckwith, Rockville
Doctor Ralph E. Kendall, Hartford
Doctor A. W. Oughterson, New Haven
Doctor F. A. Sutherland, Torrington
Doctor C. McCormack, Hartford
Doctor L. P. Hastings, Hartford
Doctor Averill Liebow, Meriden
Doctor Joseph O. Collins, Waterbury
Doctor Carl C. Harvey, Middletown
Doctor George P. Cheney, New London
Doctor M. C. Winternitz, New Haven
Doctor M. H. Griswold, Hartford
Doctor P. D. Rosahn, New Britain
Doctor William Mendelsohn, New Haven
Mr. Herbert F. Hirsche, Hartford
Mrs. Douglass O. Burnham, Watertown.

Other trustees who could not attend this meeting were:

- Doctor P. G. McLellan, Secretary, Hartford
Mr. Gerald C. Low, Treasurer, Watertown
Doctor Joseph A. Beauchemin, Middletown
Doctor Edward W. Foster, Meriden
Doctor R. R. Nesbit, New Haven
Doctor S. Bayne-Jones, New Haven
Doctor E. J. Ottenheimer, Willimantic
Doctor Stanley H. Osborn, Hartford
Doctor Maurice R. Moore, Norwich
Doctor B. M. Parmelee, Bridgeport
Mrs. Doris H. McBee, South Willington
Prof. Ira V. Hiscock, New Haven
Doctor T. H. Sills, Newington
Doctor Cecil R. Garcin, Danielson
Doctor W. Bradford Walker, Cornwall
Doctor H. W. Winters, Bristol
Doctor David Ellrich, Westport
Doctor R. A. Keddy, Stamford
Doctor Donald T. Hughson, Madison
Doctor Roy V. Sanderson, Winsted

Doctor Wilbur Moore, Cheshire
 Doctor John D. Booth, Danbury
 Doctor H. Bertram Lambert, Bridgeport
 Doctor Gray Carter, Greenwich
 Doctor Allen K. Poole, New Haven
 Doctor Irwin Granniss, Old Saybrook
 Doctor W. W. Bunnell, Farmington
 Doctor D. C. Y. Moore, Manchester.

When the Society's Tumor Committee affiliated itself with the American Society for the Control of Cancer and formed a State Committee of that organization, consisting of the members of the Tumor Committee and 27 other physicians and lay people, it was for the purpose of organizing the women of Connecticut into a Field Army to carry on a year round lay educational program.

The administration of the Women's Field Army is carried on by a State Executive Committee chosen from the Connecticut State Committee; its members are Doctor Charles L. Larkin, President, Doctor P. G. McLellan, Secretary, Mr. Gerald C. Low, Treasurer, Doctor E. J. Ottenheimer, and Doctor A. W. Oughterson. The committee appointed Mrs. Douglass O. Burnham of Watertown and Miss Mollie Cullen of Waterbury, respectively, as State Commander and State Publicity Director of the Womens' Field Army with headquarters at 101 North Main Street, Waterbury.

The State of Connecticut has been divided up into 28 districts according to population or area. Up to the present time 15 of these districts have been organized or are in the process of being organized. An attempt is being made continually to obtain the proper person to organize the remaining districts. Heading up each district is a physician appointed by the committee as chairman of a Local Executive Committee and a woman as vice commander. This Local Committee is comprised of the following members: A local publicity director, secretary, treasurer, and a representative from each professional group and social agency in the community. These members are chosen by the chairman and vice commander and should include the president of the local medical society, the local health officer, members from hospitals and tumor clinics as well as other social agencies. This committee will meet regularly to administer and approve the activities of the local unit of the Women's Field Army. In other words, all activities and publicity unless already approved by State Headquarters must go through this committee.

In contrast to this professional group, the vice commander chooses and appoints her lay group. It is this group which does the actual work in carrying out the educational program and the campaign for enlistments in the month of April. The vice commander divides her cities and towns according to their size into areas and over each one of these she appoints a captain. This captain in turn is responsible for her area and can appoint to assist her as many lieutenants as she desires or needs. This group of workers should meet about three times a year after the state meetings at which time the vice commander can instruct them. It is also recommended that a Local Advisory Board made up of prominent people and heads of local organizations be appointed. This board acts in an advisory capacity and meets but seldom.

The purpose of the Women's Field Army is to bring cancer patients to treatment early, and it is hoped that this will be accomplished through an intensive educational program. Plans are being carried out to have published in every newspaper in the state a short article on cancer at least two or three times a month and to have printed in every local and state publication an article on cancer at least once a year. An attempt will be made to place at least once a year on the programs of every local organization, such as church, industrial, social, luncheon, men's and women's groups, either speakers on cancer chosen by the local chairman or a short talk on the organization and objects of the Field Army by an officer of the Army. An effort is made the year round to distribute literature written by the Connecticut State Committee by personal contact or otherwise. The methods of accomplishing this are too numerous to be listed here, but are well known by those active in educational work.

During the month of April, which is designated as cancer control month by special act of Congress and is so proclaimed each year by the President of the United States and in turn by the governors of the states and the mayors of the cities, a campaign to enlist members in the Field Army by contributing a fee of \$1.00 is conducted in each district. Thirty per cent of the funds received is sent to the National office and the remaining seventy per cent is used in the state for administrative expenses and other projects designated by the Connecticut State Committee.

(Concluded on page 702)

THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

Charlotte Hungerford Hospital

Sixty members of the Charlotte Hungerford Hospital Auxiliary honored the retiring president, Mrs. Charles E. Bennett, by a picnic held on June 23 at the cottage of Mrs. Louis Tunick at Highland Lake. The inclement weather prevented many from attending. Mrs. Bennett was presented with a cameo brooch in honor of her two years service. Officers for the coming year are:

- President—Mrs. John H. Thompson
- Vice-President—Mrs. Alfred Lautier
- Recording Secretary—Mrs. Frank Wilson
- Corresponding Secretary—Mrs. Raymond Bartlett
- Treasurer—Mrs. Fred Sowers
- Auditor—Mrs. Raymond Bentley.

The Torrington Chapter of the American Red Cross has arranged a course in First Aid training. More than 400 persons have applied and 60 have already completed the course which required 20 hours of study. Classes have been conducted by Miss Regina McGowan, Thomas J. Ashe and John F. Richardson, Red Cross instructors. Sessions have been held at the Charlotte Hungerford Hospital and the Firehouse. Doctor Thomas J. Danaher has been certified by the National Headquarters as First Aid Instructor for Torrington. The standard course which is designed to teach practical bandaging and treatment qualifies one to act competently in an emergency pending the arrival of a physician. Those who have completed the standard course are expected to take the advance course in the fall, following the completion of which they may be certified as instructors.

A reorganization of the method of medical examinations has been effected by Doctor Harry B. Hanchett, Chief of Staff of the Charlotte Hungerford Hospital, whereby practically all members of the staff will participate in the work. These examinations are for persons who have passed through the Selective Service System, Local Board No. 30. Examinations will be held as conditions require at the Charlotte Hungerford Hospital.

The fiscal year of the Charlotte Hungerford Hos-

pital for 1940-1941 ended on June 30. The following figures may be of interest:

	1940-1941	1939-1940
No. of Patients admitted.....	3794	3487
No. of Deaths.....	141	154
No. Admitted to		
Med. Ser.	777	709
Sur. Ser.	1332	1192
Obs. Ser.	586	574
Newborn	558	553
E. E. N. & T.	541	459
Patients' Day Care—		
Private	4582	4397
Semi-Private	23086	20393
Self-Pay Wd.	5964	6869
Total number of Days Care.....	37009	35780
Daily Average	101.3	97.7
Newborn Days.....	5725	5356

The Quarterly meeting of the Board of Governors of the Charlotte Hungerford Hospital was held on June 21 under the Chairmanship of President Francis H. Griffiths.

On July 31 at Oak-Tor in Litchfield, President and Mrs. Francis H. Griffiths of the Charlotte Hungerford Hospital entertained the Senior Medical Staff and the members of the Board of Governors. Preceding the dinner various types of outdoor sports were the order of the day. In the evening the group was entertained by piano selections by Miss Jean French and violin and piano duets by Miss Marjorie Griffiths and Miss French. The speaker of the evening was Mr. Bernhard K. Schaefer, a member of the Rockefeller Commission to South America, who described in considerable detail many of the Pan American problems of which he had made a study during some fifteen years of his annual travels in South and Central American countries.

At a meeting of the newly elected officers and Committee Chairmen of the Charlotte Hungerford Hospital Auxiliary which was held on August 14, with the President, Mrs. John H. Thompson in the chair, it was voted to support the program for the enlarging of the parking space of the hospital. This is a rather important necessity and it is hoped that progress with the work can be made with little delay.

The quarterly meeting of the Board of Governors of the Charlotte Hungerford Hospital was held on July 21 with President Francis H. Griffiths presiding. The annual meeting was set forth October 20 at which time the usual election of officers will be held and the appointments to the staff will be made.

Doctor George M. Smith, a member of the State Defense Council and in charge of its medical activities, was a guest at the Charlotte Hungerford Hospital on Thursday, August 7.

On July 19, Miss Anna Elizabeth Harrison, Assistant Dietitian of the Charlotte Hungerford Hospital for the past six years, became the bride of Mr. George Delano at St. Paul's Church, Bantam. The ceremony was performed by the Rev. Chauncey Lindsley, D.D., former rector of Trinity Church, Torrington.

Colonel Samuel Fisher, Administrator of the Civilian Defense Council has announced the appointment of a Committee on Hospitalization of the State Defense Council, members of the Committee being Miss Anna M. Griffin, Doctor J. Raymond Glazier, Doctor LeRoy Leek, Doctor E. Cole Gibson, and Doctor Albert W. Buck, Chairman. This Committee which is an expansion of the State Hospital Association Committee, appointed by President Allen in November, 1940, will serve under the Division of Medicine, the Chairman of which is Doctor George M. Smith.

GRACE HOSPITAL DIET MANUAL

Special Diet Lists

(Continued from page 583)

APPROXIMATELY NEUTRAL-LOW SODIUM DIET

(Furstenburg Diet)

GROUP A—The following foods may be taken daily:

1. Eggs, meat, fish and fowl as desired.
2. Bread as desired.
3. Cereal—one of the following: Farina, oatmeal, rice, puffed rice, or puffed wheat.
4. Potato, and one or more servings of any of the following: Macaroni, spaghetti, rice, corn, cranberries, prunes, plums.
5. Milk as desired.
6. Vegetables and fruits daily of any fruit and of any vegetable not included in groups B and C as desired.

7. Butter, cream, honey, jellies, jams, sugar and candy permitted as desired.
8. Tea and coffee as desired.

FOODS TO BE AVOIDED ENTIRELY

GROUP B—All salt meats and fish, or bread, crackers, and butter prepared with salt.

Carrots.	Caviar.	Cheese.
Clams.	Cowpeas.	Endive.
Condensed milk.	Olives.	Oysters.
Raisins.	Spinach.	

FOODS NOT TO BE TAKEN MORE THAN TWICE WEEKLY

GROUP C

Lima beans.	Beets.	Buttermilk.
Cantaloupe.	Cauliflower.	Celery.
Chard.	Dried Cocoanut.	Dried currants.
Kohlrabi.	Figs.	Horseradish.
Peanuts.	Limes.	Muskmelon.
Pumpkin.	Peaches.	Mustard.
Strawberries.	Radishes.	Rutabagas.
Watercress.	Turnips.	Turnip tops.
Dates.		

Note: All food to be prepared and served without salt. No canned vegetables.

800 CALORIE SOFT DIET

BREAKFAST: $\frac{1}{2}$ cup Fruit IV; 8 ounces Skimmed milk; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup cereal.

DINNER: 1 ounce egg or chicken; $\frac{1}{2}$ cup tomato juice; $\frac{1}{2}$ cup Vegetable IV (puree); $\frac{1}{2}$ cup Fruit IV (soft); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter.

SUPPER: Soup made of 3 ounces milk, 4 tablespoons vegetable puree IV; 1 medium baked potato; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV (soft).

800 CALORIE REGULAR DIET

BREAKFAST: $\frac{1}{2}$ cup Fruit IV; $\frac{1}{2}$ cup cereal; 8 ounces skimmed milk; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter.

DINNER: 1 ounce meat, fish, cheese, or egg; $\frac{1}{2}$ cup Vegetable I (raw); $\frac{1}{2}$ cup Vegetable I (cooked); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV.

SUPPER: 1 ounce meat, fish, cheese, or egg; $\frac{1}{2}$ cup Vegetable I (raw); $\frac{1}{2}$ cup Vegetable I (cooked); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV; 8 ounces skimmed milk.

SAMPLE MENUS

800 CALORIE SOFT DIET

BREAKFAST: 4 ounces orange juice; $\frac{1}{2}$ cup farina; 8

ounces skimmed milk; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter; Coffee.

DINNER: Clear broth; Hot sliced chicken (white meat); Fat free carrot puree; $\frac{1}{2}$ cup stewed pears (without sugar); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; 4 ounces tomato juice; Tea.

SUPPER: Soup made of 4 ounces milk, 4 tablespoons fat free pea puree; Baked potato; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup stewed peaches (without sugar); Tea.

800 CALORIE REGULAR DIET

BREAKFAST: 4 ounces orange juice; $\frac{1}{2}$ cup farina; 8 ounces skimmed milk; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter; Coffee.

DINNER: Clear broth; Roast beef (small servings); $\frac{1}{2}$ cup fat free asparagus; Lettuce and tomato (no dressing); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; Small baked apple (without sugar); Tea.

SUPPER: Clear broth; Poached egg on $\frac{1}{2}$ slice toast; $\frac{1}{2}$ cup fat free spinach; Head lettuce (no dressing); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup fresh fruit; 8 ounces skimmed milk; Tea.

1000 CALORIE SOFT DIET

BREAKFAST: $\frac{1}{2}$ cup Fruit IV; $\frac{1}{2}$ cup cereal; 8 ounces skimmed milk; 1 egg; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter.

DINNER: 1 egg or 1 ounce white meat chicken; $\frac{1}{2}$ cup potato; $\frac{1}{2}$ cup Vegetable III puree; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV.

SUPPER: Soup made of 3 ounces milk, 4 tablespoons vegetable puree IV; 8 ounces skimmed milk; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV; 1 egg.

1000 CALORIE REGULAR DIET

BREAKFAST: $\frac{1}{2}$ cup Fruit IV; $\frac{1}{2}$ cup cereal; 8 ounces skimmed milk; 1 egg; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter.

DINNER: 1 ounce meat, fish, cheese, or eggs; $\frac{1}{2}$ cup potato; $\frac{1}{2}$ cup Vegetable I (cooked); $\frac{1}{2}$ cup Vegetable I (salad); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV.

SUPPER: Meat, fish, cheese, or 1 egg; $\frac{1}{2}$ cup Vegetable III; $\frac{1}{2}$ cup Vegetable I (salad); $\frac{1}{2}$ slice

bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup Fruit IV; 8 ounces skimmed milk.

SAMPLE MENUS

1000 CALORIE SOFT DIET

BREAKFAST: 4 ounces orange juice; $\frac{1}{2}$ cup farina; 8 ounces skimmed milk; soft cooked egg; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter; coffee.

DINNER: Clear broth; hot sliced chicken; fat free mashed potato; fat free spinach puree; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup fresh applesauce (without sugar); tea.

SUPPER: Soup made of 4 ounces milk, 4 tablespoons fat free pea puree; 8 ounces skimmed milk; soft cooked egg; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup stewed peach (without sugar).

1000 CALORIE REGULAR DIET

BREAKFAST: 4 ounces orange juice; $\frac{1}{2}$ cup farina; 8 ounces skimmed milk; soft cooked or poached egg; $\frac{1}{2}$ slice toast; $\frac{1}{2}$ pat butter; coffee.

DINNER: Clear broth; pot roast of beef (small serving); fat free mashed potatoes; fat free spinach; lettuce and tomato (no dressing); $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup stewed peach (without sugar).

SUPPER: Clear broth; 1 ounce American cheese; $\frac{1}{2}$ cup fat free sliced carrots; celery hearts; $\frac{1}{2}$ slice bread; $\frac{1}{2}$ pat butter; $\frac{1}{2}$ cup fresh applesauce (without sugar); 8 ounces skimmed milk.

The School Lunch

The Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association is emphasizing the importance of the school lunch, that it should include proper quantities of calcium, vitamin B₁ and, in certain geographical areas, iron, iodine and the pellagra preventive factors (nicotinic acid, riboflavin), that it should be varied and attractive, and that sufficient time should be allowed for leisurely consumption.

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Members of the Connecticut State Medical Society Ordered to Active Duty (As of August 9)

Frank Mongillo, New Haven

Previous Orders Revoked

James R. Gudger, West Hartford
 Howard R. Hansell, Sharon
 Henry R. Lewis, Wethersfield
 Lewis Thorne, New Haven

Ordered to Active Duty by the War Department, Washington

Lewis Thorne, New Haven

Changes in Selective Service Organization

Hartford Medical Advisory Board

Thomas N. Hepburn added as urologist.

New Haven Medical Advisory Board

Carl W. Henze added as orthopedist.

Board 6B

Charles G. Paolillo, New Britain, alternate examiner.

Board 9A

Joseph Petrelli, New Haven, alternate examiner.

Board 14A

Nehemiah A. Towne, Naugatuck, alternate examiner.

Board 17B

George D. Burns, Derby, alternate examiner.

Board 23A

Nicholas E. Creaturo, Bridgeport, alternate examiner.

Vacancies in the U. S. Naval Reserve Medical Corps

A number of vacancies have been created in the Medical Reserve Corps of the United States Navy. These include the rank of Lieutenant, Junior Grade and Lieutenant also a number of appointments as Lieutenant Commander for Special Service (surgeons, orthopedists, otolaryngologists, neurologists, urologists, internists, neuro-psychiatrists, radiologists and pathologists).

Further information is obtainable on communicating with the District Medical Officer, Headquarters, Third Naval District, 90 Church Street, New York City, the telephone number is Rector 2, 9100, or the office of the Secretary of The Connecticut State Medical Society.

Doctor McDonnell Reports On Halifax Program

Doctor Ralph E. McDonnell, Chairman on Medical Preparedness for New Haven County, recently visited Halifax, Nova Scotia, and brought back a

report of the disaster emergency plans of that Canadian City, and the details of the air warden organization, black-out plans, and many other details of the Defense Program.

Doctor McDonnell presented his report to a meeting of the Society's Committee on Medical Preparedness at the State Armory late in July.

Conference With Medical Director Office of Civilian Defense

Doctor George Baehr of New York, who is the Director of Medical Services in the Office of Civilian Defense for the United States under Mayor LaGuardia, entertained Doctor Smith, the State Preparedness Chairman, and the Executive Secretary, at a day long conference at his residence at Weston, on August 2. The New York plans for medical service in the Civilian Defense were discussed in fine detail, and the conference offered an unusual opportunity to become familiar with state participation in the country's program.

Participation of State Institutions in Emergency Hospitalization Plans

The participation of State hospitals and institutions in the Defense Program was discussed at a meeting at the office of the Defense Council at the State Armory in Hartford on July 30. Those attending were: George M. Smith, State Preparedness Chairman; Doctor Roy L. Leak, Supt., Conn. State Hospital, Middletown; Doctor Cole B. Gibson, Supt., Undercliff Sanatorium, Meriden; and representatives of the Hospital Association: Doctor Wilmar M. Allen, Hartford; Miss Anna P. Griffin of the Danbury Hospital; Albert W. Buck of the Charlotte Hungerford Hospital; Doctor J. Raymond Glazier of the Hartford Hospital, Mr. John Andrews, the Planning Division of the State Defense Council. Plans for the integration of hospital beds that may be available in state institutions with the program for emergency hospitalization in the state are being developed.

Doctor George Baehr of New York, who is the Director of Medical Services in the Office of Civilian Defense for the United States under Mayor LaGuardia, entertained Doctor Smith, the State Preparedness Chairman, and the Executive Secretary, at a day long conference at his residence at Weston, on August 2. The New York plans for medical service in the Civilian Defense were discussed in fine

detail, and the conference offered an unusual opportunity to become familiar with state participation in the country's program.

Medical Advisory Board Office of Civilian Defense

The United States Director of Civilian Defense has appointed a medical advisory board to assist the medical division of the Office of which Doctor George Baehr of New York is chief medical officer. The Medical Advisory Board consists of Doctor George Baehr, Chairman; Doctor Robin C. Buerki, Madison, Wisconsin; Doctor Elliott Cutler, Boston, Massachusetts; Doctor Oliver Kiel, Wichita Falls, Texas; Doctor Albert McCown, Washington, D. C.; and Doctor Fred Rankin, Lexington, Kentucky.

Air Raid Warden Schools in Connecticut

HERBERT D. GALLAUDET, *Director of Air Raid Warden Schools*

The State Defense Council directed the organization of two schools for air raid wardens which were opened early in July. These schools made a beginning toward providing this essential civilian defense service for the State. In organizing the schools efforts were made to make the course available to many types of persons with varieties of outlook and experience. The New Haven school was held during the day, two three hour sessions on four successive days, and in the Hartford school the courses were given in the evening from 7:30-10:00. Three hundred and eighty seven men and women registered for the New Haven courses and seven hundred and fifty three at Hartford. The persons taking the courses furnished an interesting cross-section of occupation and ability. The group of over eleven hundred included firemen and policemen, factory executives and foremen, school teachers, business men and many just plain citizens of both sexes who enrolled, some perhaps from curiosity, but most of them with the genuine willingness to be of patriotic service. At the New Haven School there were many enrollees who lived at some distance and these persons stayed in New Haven throughout the course.

In their essentials the same course was given in both of the schools and largely by the same instructors. The course included the warden's work and duties, and his place in the air raid precautions organization received particular emphasis. The relation

of the air raid warden to the police and fire services and to special defense services such as medical relief, rescue, demolition and engineering was also taken up. Doctor Joseph I. Linde of the Mayor's Defense Committee in the City of New Haven discussed the relation of the air raid warden and medical service at the School in New Haven and Doctor Ralph E. McDonnell, New Haven County Chairman on Medical Preparedness, gave this instruction at the Hartford School.

The courses included lectures on gas protection and decontamination, on the chemistry of incendiary fires, on black-out methods, on improvised shelters, and methods for dealing with incendiary bombs and treatment of high explosives. First aid was not included since Red Cross courses in first aid are readily available in communities throughout the State. It was interesting and valuable to note that between a quarter and a third of the persons enrolled for the Air Raid Warden Course had already completed the Red Cross course in first aid. The importance of first aid instruction was stressed to the persons taking the air raid warden instruction.

Air Raid Warden Course certificates were given to those who attended these courses regularly and each candidate submitted a brief outline making suggestions for the adoption of the warden program to the needs of their own city or town, the plant where they were employed or some other social or industrial unit. A copy of each of these plans was sent to the local defense committee in the community where the student resided and the statements offered many practical suggestions. The proposals made by some of the students are being used as a basis of future programs in a number of communities. It is contemplated that other schools in instruction for air raid wardens will be held in various parts of the State.

The New Warfare

If war methods have already shown radical changes over the last war, they may certainly be expected to show further change before this one has progressed much further. Gas and bacterial bombs have not been used, it is true, because the advance of the Nazi army, so far, has not warranted the risk of reprisals, but I am convinced that these will be used before the termination of the war. Gas bombs are made of various toxic substances, the lachrymal, the asphyxiating, the paralyzing and the blistering

types being among the possibilities available in this remaining method of attack. Gas masks are not capable of neutralizing all types of gases. They are only effective for a duration of 8 to 12 hours. If not employed, the capsules of chemical ingredients must be replenished every 4 to 6 months.

The lessons of the European conflict are obvious. Civilian evacuation, transportation, housing in refuged areas, supplies, food, air-shelters, medical and hygienic cares and many other factors are involved. There is much to be done and, truly, little time in which to do it.

Dig. of Treatment, April 1941.

New Searle Laboratories

The G. D. Searle & Co., a well known pharmaceutical manufacturing firm in Chicago, is building on the outskirts of Chicago an entire new plant, including laboratories. The building will be completely modern in design and not factory like in its appearance, will be made of reinforced concrete, flat-slab set-back type of building with three stories and basement of 1,500,000 cubic feet. The exterior is to be a modern streamlined design using white face brick with Bedford limestone, with continuous windows protected by projecting metal fins, all window frames to be of steel with glass bricks in places. Air conditioning will be installed throughout. There will be an auditorium, a recreational center, research laboratories, scientific library, an emergency hospital and animal rooms.

FROM THE SECRETARY'S OFFICE

(Continued from page 696)

During last April a campaign was conducted in the seven districts which were organized at that time. About 30,000 pamphlets were distributed, 800 counter cards placed, and approximately 200 inches of publicity accepted by newspapers. The results so far have not been very encouraging owing to the fact that organization was started at such a late date, but it is the hope and expectation of the committee that during the coming year more than one half of the state will be well launched on this program. In the meantime, officers of the fifteen organized districts are being urged to lay the foundation this summer for an efficient and permanent local unit, and to constantly pound into the heads of the public through publicity the fact that early cancer is curable; FIGHT IT WITH KNOWLEDGE!

PUBLIC AFFAIRS

It is planned to make this section on public affairs a permanent department of the JOURNAL. In it there will be discussions of state and federal government developments that affect the practice and profession of medicine. Comment on the contents of this section will be welcomed and suggestions from members as to topics that might be discussed are solicited. (The Editor).

News from Washington

MATERNAL AND CHILD HEALTH AND WELFARE

ACTIVITIES RESTRICTED

Among the estimates that the President transmitted to Congress for supplemental appropriations totaling \$158,667,020 was \$878,000 for all expenses necessary to enable the Secretary of Labor to assist state and local authorities in the promotion of maternal and child health and child welfare in areas effected by national defense activities, including personal services in the District of Columbia and elsewhere.

In support of the supplemental estimate Miss Katharine Lenroot, Chief of the Children's Bureau testifies in part as follows:

"Striking evidence of the need for maternal and child-health personnel in defense areas is shown in information received by the Children's Bureau from 34 State health agencies. We have very recent information from those agencies which has come in since we submitted our estimate to the Bureau of the Budget and which indicates a need far in excess of what we have here. But we do feel, with the additional personnel that would be made possible by this appropriation, we could greatly assist the States in meeting their most urgent needs and in planning for additional resources, either State or local, to provide for more adequate services.

"Now, in order to meet these situations on a minimum basis and as quickly as possible, the Children's Bureau, in conference with representatives of the State agencies responsible for both health and welfare, devised this plan whereby we would add to the staff of the Children's Bureau a certain number of medical officers and public health nurses; graduate nurses to assist in child health clinics and conferences; a few nutritionists; and child welfare workers; that these workers would be employed under civil service, just as our other staff is employed, but they would be, for the most part, assigned to State agencies of health and welfare with which we are already cooperating under the Social Security Act,

under agreements with those agencies as to the communities in which the workers would be placed and the services which they would perform . . ."

INTERFERENCE WITH PRIVATE PRACTICE

In response to a question submitted by Representative Tarver, Georgia, as to whether these medical officers so assigned would undertake to supply general medical services in areas around cantonments and military posts, Miss Lenroot replied:

"They would work primarily in maternal and child health conferences and clinics and as consultants, to such practicing physicians as are available, who would not have the special background in obstetrics or pediatrics, which would be necessary in certain types of cases. I would presume, also, these medical officers would actually take care of sick children if there was no other medical service available in the community."

Pursuing this thought further, Representative Tarver said:

"There is another thing, it seems to me, that ought to be taken into consideration, and that is that these workers in defense areas are getting much higher wages than the ordinary worker in the United States in other types of industry, and I am wondering what justification there is for the Federal Government to provide medical services and nursing services for his family and his children, when the same type of service is not provided for workers in industry and for other citizens of the country.

"It is my observation that doctors and nurses usually go to localities where they can get patients for good pay, and, if there is not a sufficient number of physicians and nurses in those localities for service to families where the well-paid workers are located, I think it would probably be quite as easy a matter for physicians and nurses in private practice to be attracted to those localities as for you to employ them at public expense and send them there."

HYSTERIA

Representative Keefe, of Wisconsin, expressed

himself as disturbed by the thought that if the appropriation asked for be made, a program would be initiated under emergency conditions that would not be terminated after the emergency had ceased to exist. He said:

"I am exceedingly interested in the extension of this type of service within the ability of the people of this country to sustain the program. But I am frank to say that the presentation of this matter, as it impresses me, indicates a good deal of hysteria. Now, I have received letters—I suppose because I am a member of this committee; I do not know any other reason why I should receive them—but I have received letters from public health officers and organizations from one end of the country to the other, all of them proclaiming the great need that exists. Granted. You say that you can only just scratch the surface of it with what you are asking here now; you can only fill a little bit of the need. Well, is this going to mean, then that this thing is going to grow and grow and grow until we ultimately achieve the ideas of all these social workers throughout the country as to what they think is necessary for child welfare and maternal care and all that sort of thing throughout the whole country?

"Has there been any evidence of any epidemic in any of these places? Has there been any evidence of any deaths resulting from malnutrition or lack of proper care during childbirth or anything of that kind? Is there any evidence available to show any of those things?

" . . . I am frank to say that my short experience in national affairs leads me to conclude that once one of these things gets under way, and once the personnel is established, and once the program is established, it is going to be mighty difficult to keep it from being established forever, despite all the optimism that you display that this is not a permanent program, and that you would like to see it restored to the original status . . ."

APPROPRIATION DENIED

In reporting the appropriation bill to the House, the Committee on Appropriations refused to include in it the specific appropriation under discussion and justified its action in the following words:

"A supplemental Budget estimate of \$878,000 was submitted to Congress in House Document 211 for the purpose of authorizing the Children's Bureau to undertake the task of supplying services to cope

with the problems presented in adequately caring for maternal and child health and welfare in defense areas that have developed in mushroom fashion and where State and local facilities are not sufficient to supply the health needs of the mothers and children resident in these localities.

"As a matter of national policy we have embarked upon a program of grants to States for maternal and child health and welfare. The States, under the terms of these grants, are required to match the Federal funds so given them with certain State moneys. To now embark upon a policy of giving direct Federal aid in these defense areas would be to do violence to the general policy that has been laid down and would doubtless tend to commit the Federal Government to a program of direct Federal participation in a program of maternal and child health and welfare. No such program of this nature is at present authorized by Congress and while there is some division in the subcommittee as to whether the Federal Government should or should not project itself into this picture as an emergency measure, the subcommittee is unanimous in its thought that the subject is of sufficient importance from a policy standpoint as to justify the proper legislative committee reviewing the matter of need and justification for Federal participation with a view of authorizing Federal assistance within defined limits or denying it altogether as the case may be. States and localities have clamored to be beneficiaries of Federal construction for national defense. It does seem to the committee therefore, that those States and localities that have been successful in their quest and have, as a result thereof, increased tremendously their State wealth should proceed to levy taxes sufficient to care for the problems of social welfare that ensue in the wake of vast concentrations of population in these defense areas."

Osteopathy Marches On

A House resolution providing for sundry matters affecting the military establishment and containing an authorization under which the Secretary of War will be permitted to provide for the employment of "internes who are graduates of or have successfully completed at least four years' professional training in reputable schools of medicine *or osteopathy* in the medical department and not to exceed \$750 per annum," was passed by the House and sent to the Senate.

(Concluded on page 713)

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

CLIFFORD KUH, M.D., Chairman, New Haven

JAMES J. DONOHUE, M.D. Norwich	MARTIN I. HALL, M.D. Bristol	JOSEPH A. LAPALME, M.D. Putnam	PAUL W. VESTAL, M.D. New Haven
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ALBERT S. GRAY, M.D. Hartford	ARTHUR B. LANDRY, M.D. Hartford	RICHARD O'B. SHEA, M.D. Bridgeport	

Bacterial Counts on Industrial Oils

The Manufacturers Association of Connecticut on behalf of its members has investigated the question of bacterial contamination of machine oils and issued a memorandum on the subject, at the same time announcing a special service for industrialists and plant physicians.

A new oil produced under proper sanitary conditions, according to the memorandum, contains few, if any, bacteria, but during use the numbers of bacteria will vary more or less with the sanitary precautions observed by the machine operators. The oils appear to be inert to bacterial life, being neither germicidal, antiseptic, nor do they ordinarily support bacterial life. Samples showing a high bacterial count, therefore, represent the result of unsatisfactory operating conditions. It is not usually necessary to make a more expensive differentiation test to determine the nature of the bacteria.

Oils have an irritating effect on the skin of certain individuals and tend to lower the skin resistance to infections. One employee suffering from boils, furuncles, or other similar infections, may very readily spread infection to all of the other susceptible employees using the same oil through his carelessness in allowing the oil to run over his infected hands or arms. Even employees who might not ordinarily be affected by dirty oils because of a natural skin resistance are open to the danger of infection if the oils are used for considerable periods and accumulate fine particles of steel, which cut through the skin and allow harmful bacteria to enter.

Dirt and fine particles of metal can be removed from the oil by means of centrifugal machines and such treatment results in a very considerable reduction in the bacterial count. Pasteurization or some other means of disinfection should supplement the

centrifugal clarification. Many plants are now installing oil filter equipment for circulating oil systems. The best types remove the suspended matter after which the oil is heated to a temperature of about 140° to 145° F. for a period of twenty to thirty minutes. Certain disinfectants may be added to the oil.

With all of these precautions, accidental contamination still occurs and it is extremely desirable to check up on the above-mentioned protective measures by means of routine bacterial examinations.

It is proposed that several companies submit samples of oil on the same day in order to obtain a special rate for the bacterial count. Details will be given upon request to the Committee on Industrial Health.

Michigan Uses Connecticut Plan

As a guide in the development of their industrial health program the Michigan State Medical Society is following the brochure, "Conservation of Man Power," prepared by the Joint Committee on Industrial Health of the Manufacturers Association of Connecticut and the Connecticut State Medical Society, with this variation: Instead of considering the state as a promotional unit, two counties, having county committees on industrial health, have been selected for intensive development. These counties are large and widely separated industrial centers and, if the experiment is successful, the program will then be extended to other counties. As in Connecticut, the active promotional phases will be brought to the attention of individual plants by the manufacturers association.

Utilization of the Connecticut brochure in other localities has been so gratifying, that a fourth edition has now been published. The first print order for

approximately 1600 copies was increased by 100 and later by 250. The new edition is for 800.

Variations in Absenteeism

One of Connecticut's industrial physicians, Doctor Bernard S. Dignam, Thompsonville, has analyzed the 1940 records of absenteeism, available under a group insurance plan for that city's Bigelow Sanford Carpet Company, which he attends, and has published the figures in *Industrial Medicine*, June, 1941. Non-occupational injury and illness account for only five times as much lost time as industrial injuries, which is less than that reported by M. N. Newquist in his well known "Medical Service in Industry and Workmen's Compensation Laws" (American College of Surgeons), where the figure is fifteen instead of five. The difference may be due to the fact that in Dignam's article non-occupational injuries and illnesses, entailing lost time of one week or less, are not covered by the insurance carrier and, hence, are not included.

Accident Rates

The average accident severity and frequency rate of a number of companies may be a gauge whereby the industrial physician can evaluate the experience of his own plant. Over three hundred New England defense industries employing 205,138 workers report 21,537 days lost in April, 1941, through accidents. This gives the relatively low severity rate of 0.61. The number of accidents involved is not stated. However, 325 Massachusetts companies employing 177,237 workers (defense and non-defense industries) having a similar severity rate (0.65) for the entire year, 1940, had a frequency rate of 10.0. The national rates for 1940 (5,163 companies employing 3,656,782 workers) were 12.5 for frequency and 1.44 for severity.

The Industrial Nurse Consultant

Connecticut and six other state industrial hygiene bureaus now have an industrial nurse consultant,

whose function is to improve the status of nursing service in industry.

The Division of Industrial Hygiene of the National Institute of Health, Bethesda, Maryland, has also had assigned to it a nursing consultant in a similar capacity. An Industrial Hygiene Institute for Consultant Nurses was sponsored by the Division and held last April, when a broad program was proposed. As part of this program a survey of present industrial nursing practice is now being conducted under the auspices of the Committee to Study the Duties of Nurses in Industry of the Nursing Section of the American Public Health Association.

Outline for Speakers

The fact that physicians not infrequently have an opportunity to address lay audiences has been recognized by the development of a speakers' bureau in the Society's Public Relations Committee. To assist physicians who may be called upon to address industrialists, foremen or supervisors, a suggested outline has been prepared and is available upon request to the Committee on Industrial Health. There has also been prepared a list of sources of literature for distribution to employees on the subject of health and safety, posters for display, and the like.

Changes in Name

The Bureau of Occupational Diseases of the State Department of Health will henceforth be known as the Bureau of Industrial Hygiene. This broader appellation is welcome because the Bureau has long ceased to concern itself merely with the control of occupational disease. Industrial hygiene, like child hygiene or mental hygiene, has adopted a positive attitude toward the fostering of public health.

Similarly one of the most important research and educational institutions in the field has long hidden its light under the name, "Air Hygiene Foundation of America" (Pittsburgh, Pa.). It now becomes more closely identified in terminology with its true domain as the "Industrial Hygiene Foundation of America."

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SPECIAL NOTICES

TRUDEAU SCHOOL OFFERS FALL COURSE — SCHOLARSHIPS AVAILABLE

The 27th session of the Trudeau School of Tuberculosis will be held at Saranac Lake, N. Y., September 8 through October 3. A supplementary and optional course will be given at Bellevue Hospital, New York City, October 6-17.

The essentials of the history, etiology, epidemiology, pathology, diagnosis, prognosis and treatment of tuberculosis will be presented during the four-week Saranac Lake course. Emphasis will be placed on bedside teaching and the clinical study and treatment of patients, combined with x-ray and pathological conferences. Two elective courses, institutional management and the bacteriology of the tubercle bacillus, will be offered.

The two-week course at Bellevue Hospital, which can be taken by those completing the work at Saranac Lake, is offered by the Faculty of Medicine of Columbia University, under the direction of Doctor J. Burns Amberson, Jr. and Doctor Frank Brown Berry.

The physicians enrolled in this course will participate actively in the examination of patients and in presenting them at clinical conferences. Special aspects of tuberculosis to be considered include the manifestations of the disease in children, tuberculosis of the skin, bones and joints. Lymphopneumogenous forms will also be considered.

Diagnosis, differential diagnosis, and the management of various non-tuberculous diseases of the chest will be emphasized. Opportunities will be given to attend operative and bronchoscopic clinics.

The fee for the course, including the optional two weeks at Bellevue Hospital, is \$100. All applications should be addressed to Roy Dayton, secretary, Trudeau School of Tuberculosis, Saranac Lake, N. Y.

As in former years the Trudeau School has given the National Tuberculosis Association two scholarships, covering the tuition fee, to be assigned to suitable applicants. In addition, the NTA will offer three such scholarships. Correspondence regarding the scholarships should be addressed to Doctor Kendall Emerson.

NATIONAL SOCIETY FOR PREVENTION OF BLINDNESS

The 1941 annual meeting of the National Society for the Prevention of Blindness will be held in New York City, December 4 to 6, it is announced by Mrs. Eleanor Brown Merrill, Executive Director.

Mrs. Merrill announced, also, the addition of four new members to the Society's Board of Directors: Mrs. Julius Ochs Adler, New York City; Miss Edith M. Baker, Principal Consultant in Medical Social Work, United States Children's Bureau, Washington, D. C.; Doctor Herman E. Hilleboe, Medical Coördinator, Department of Social Security, Minnesota State Division of Social Welfare, St. Paul, Minn.; and Mr. R. Amory Thorndike, Bar Harbor, Me.

MEETING OF SCIENTIFIC PHOTOGRAPHERS

The Biological Photographic Association, an international group of photographers in the natural sciences, will hold its 11th annual meeting in the Hotel Buffalo, Buffalo, New York, September 11-13, 1941.

The program, in which a number of outstanding photographers and other technical experts will participate, emphasizes this year methods and processes which are likely to contribute to the national defense.

The annual salon, now well known to photographers through the pages of the photographic magazines, will again be a prominent feature of the meeting. Visitors are welcome.

For further information write the Secretary of the Biological Photographic Association, University Office, Magee Hospital, Pittsburgh, Pa.

ANNOUNCING THE EIGHTH INSTITUTE ON PUBLIC HEALTH EDUCATION

Atlantic City, N. J., October 12, 13 and 14

For the eighth time, the American Public Health Association, through its Section on Public Health Education, and in connection with its Annual Meeting, offers those with responsibilities wholly or partly in the field of health education, the opportunity to enroll for a short, intensive course in the philosophy, principles and methods of educating the public for health.

This year, of all years, the obligation to teach health effectively is a heavy one. Upon the physical and mental health of the nation depends a large share of the success of the defense program. The Health Education Institute will provide health educators with the means to serve the nation better. The slogan of the Institute might well be "To help health educators to help the population to help themselves to a higher state of physical and mental well-being."

The Institute begins on Sunday, October 12, and continues to Tuesday noon, October 14. The sessions of the 70th Annual Meeting start on the 14 and end on October 17. It is hoped that all who attend the Institute will remain for the equally important meetings of the Health Education Section and the other nine Sections of the Association.

The preliminary program for the Annual Meeting was published in the August issue of the American Journal of Public Health.

Fees: The registration fee for the 8th Institute on Public Health Education is \$3.00 for members of the American Public Health Association. It is \$6.00 for non-members.

Enrollment: Application for enrollment should be made on the official letterhead of the applicant. The fee must accompany the application. The registration list will be closed at the discretion of the Institute Committee.

Eligibility for Enrollment: Any person engaged in or interested in health education may apply.

Address all communications to the American Public Health Association, 1790 Broadway (at 58th Street), New York, N.Y.

FALL MEETING EYE, EAR, NOSE AND THROAT SECTION

The annual fall meeting of the Eye, Ear, Nose and Throat Section of the Society will be held at the Torrington Country Club commencing at 3:00 o'clock in the afternoon on September 25. The program as announced by Doctor William H. Ryder, the Chairman of the Program Committee, will be: Analysis of Strabismus Work by the New Haven Dispensary
Clement C. Clarke, New Haven

Supplementary Report on the Therapy of Deafness
Norton Canfield, New Haven

and a paper, When Should Tonsils Be Removed, by a speaker to be selected. Members of the Section and other interested physicians are invited. Dinner will be served.

EXAMINATIONS, AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 3, 1942, at 2:00 P. M. Candidates who successfully complete Part I examinations proceed automatically to the Part II examinations later in the year.

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 1, 1941. Applications for Group A must be in the Secretary's office by March 1, 1942.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Atlantic City, N. J., immediately prior to the 1942 meeting of the American Medical Association.

As previously announced in the Board booklet, this fiscal year (1941-1942) of the Board marks the close of the two groups of classification of applicants for examination. Thereafter, the Board will have only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Doctor Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

SECOND CONGRESS ON OBSTETRICS AND GYNECOLOGY

The arrangements for the Second American Congress on Obstetrics and Gynecology to be held in St. Louis, Missouri, from April 6-10, 1942, are progressing according to schedule. The various committees have been formed and are ready to

function. The general program of meetings has been set up and meeting rooms in the St. Louis Auditorium assigned.

The program contemplates meetings of individual sections, of combined sessions and of general sessions. Round table or panel discussions will be held by those sections which desire them. There will be evening sessions for the laity as well as for the members. Probably two evenings will be assigned to each type of meeting. The subjects and speakers will be announced later. Doctor Robert L. DeNormandie is Chairman of the committee on public meetings.

There will be moving picture exhibits, and it is planned to devote the first morning exclusively to registration and moving picture exhibitions. Doctor Robert D. Mussey is chairman and Doctor M. E. Davis is Secretary of this committee.

The committee on scientific and education exhibits is headed by Doctor H. C. Hesselstine with Doctor Charles Galloway as Secretary. They are planning a larger and better exhibit than the excellent one of 1939.

RETURN YOUR INFORMATION CARD FOR THE DIRECTORY PROMPTLY

About September 1, an information card will be sent from the headquarters office of the American Medical Association to every physician in the United States and Canada. The information secured is to be used in compiling the Seventeenth Edition of the AMERICAN MEDICAL DIRECTORY.

The directory is prepared at regular intervals in the Biographical Department of the American Medical Association. The last previous edition appeared in 1940. This volume is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States; it has been especially valuable in the medical preparedness program. In it, as in no other published directory, are dependable data concerning physicians, hospitals, medical organizations and activities. The directory provides full information concerning medical colleges, specialization in the field of medical practice, memberships in special medical societies, tabulations of medical journals and medical libraries and, indeed, practically every important fact concerning the medical profession in which anyone might possibly be interested.

Before filling out the information card, read the instructions carefully. Physicians are especially urged to state whether or not they are on extended active duty for the medical reserve corps of the United States Army and Navy. Fill out the card and return it promptly whether or not a change has occurred in any points on which information is requested. If a change of address occurs before March 1, 1942, report it at once. Should you fail to receive a card before the first of October, write at once to the headquarters office stating that fact and a duplicate card will be mailed.

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OUR NEIGHBORS

Maine

The total membership of the Maine Medical Association is 783, an increase of 16 in the past year. Two County Societies united during the year so that the Association now comprises fifteen County Societies. At the last session of the Legislature, the Cancer Committee successfully sponsored a bill to create a Bureau for Cancer Control. The new president is P. L. B. Ebbett of Houlton, the new president-elect, Carl H. Stevens of Belfast.

Massachusetts

The total membership of the Massachusetts Medical Society is now 5639, an increase of 97 in the past year. The new president is Frank R. Ober of Boston, the new president-elect, George L. Schadt of Springfield.

New York

The editors of the New York State Journal of Medicine have found time to make a tour of inspection of the army posts and camps located within the boundaries of that State. These visits were made possible through the courtesy of the military authorities of the Second Corps Area. Their report as to conditions found was very favorable. The hospitals are adequate in size and well equipped, drugs are well stocked, buildings are scrupulously clean, and the food both in the officers and enlisted men's mess is good and substantial. They report the hospitals conducted with well organized services in medicine and surgery and with most of the special services represented. The staffs in most cases are up to full complement. Venereal disease seems to be well under control, due to the excellent cooperation between the civil and military authorities, in fact, the opinion was expressed that venereal disease in the Army is on the decrease.

New York City Selective Service Administration, on recommendation of Colonel Kopetzky, Chief of the Medical Division, has set in motion a rehabilitation program whereby the practical means to arrange for the treatment of registrants will be available. This has resulted from a discovery of the fact that over 80% of all New York City registrants qualified only for limited military service have but

one medical defect. It is the belief of the Medical Division that many of the defects can be easily remedied so that men will be available for full military training in a short time. The most frequent causes for qualifying a registrant for limited military service, according to the New York City Area report, are: Defects of the Eyes and Teeth, 10.39% and 9.39%, respectively; Genitourinary Organs and Venereal Disease, 3.63%; Abdominal Organs and Wall, 3.56%.

NEWS

from County Associations

Fairfield

The following appointments have been announced by the Board of Directors of the Stamford Hospital.

Chief of Staff: J. Howard Staub.

To the Medical Board: Russell A. Keddy.

Assistant obstetrician and gynecologist: Edward B. Hopper.

Assistant surgeon: Edward F. Malloy.

Associate staff: Walter G. Crump, Jr., Gilbert E. Moore, Eric Twachtman, Leo E. Smith.

Litchfield

Word has recently been received that Captain William C. Kennedy of the 102nd Infantry's Medical Detachment since 1927 has been promoted to the rank of Major. Major Kennedy entered the army with a rank of captain, having served in the National Guard with rank of captain since 1927, and recently completed a month's refresher course for medical officers at the Carlisle Barracks, Carlisle, Pa. He is now stationed at Camp Blanding, Fla. Major Kennedy has been a practicing physician in Torrington since 1915 and during the World War served as a member of the district medical examining board and was a battalion adjutant in the Connecticut Home Guard.

The versatility of the physicians of Connecticut is so well exemplified by the following as to be worthy of note. A recent copy of the Torrington Register gives the following: "Miss Barbara Van Doren, daughter of Carl Van Doren, author and critic, and Mrs. Irita Van Doren, literary editor of the New York Herald Tribune, became the bride on

Saturday of Spencer Klaw, son of Alonzo Klaw, former theatrical manager, now of Carmel, N. Y., and Mrs. Alma Klaw. Reverend Doctor Bradford Walker, probate judge, of Cornwall officiated."

First Lieutenant Robert A. Walker of Cornwall is now assigned to the Medical Detachment of the Windsor Locks Airport. During the summer Doctor and Mrs. Walker will continue to reside in Cornwall and in the fall will take up their residence in Enfield.

E. H. Wray, Lt. S. G. Medical Corps, U. S. Navy, is now stationed at the Brooklyn Navy Yard.

Middlesex

Doctor Norman E. Gissler, a member of the surgical staff at the Middlesex Hospital, leaves early in September for a year of post graduate study in surgery under Doctor Arthur Wright at the Bellevue Hospital in New York City.

Announcement was recently made that Doctor Charles A. Russman who has served as clinical director of the Connecticut State Hospital since 1939 has received the appointment of assistant superintendent at the institution. Doctor Russman was certified by promotional examination through the merit system. He was appointed to the staff in 1924 as assistant physician, and promoted to senior physician in 1926.

Doctor Joseph Beauchemin of the Connecticut State Hospital has been named by Governor Robert A. Hurley as one of the members of the State Board of Examiners for physical therapy technicians.

Doctor James A. Murphy of Middletown has been reappointed a member of the Middletown Board of Health by Mayor James Connery. Doctor Murphy completed a term of four years, having been named to the board at the time of its organization in 1937.

Doctor Sidney Chait, resident physician at the Middlesex Hospital, was married on June 23 to Miss Victoria Mikuszewski who is a member of the nursing staff of the Middlesex Hospital.

Doctor Walter Schloss who completed his internship at the Middlesex Hospital in June has accepted a residency in neurosurgery at the Bellevue Hospital in New York City.

Doctor Benjamin Shenker who was resident at the Middlesex Hospital last year has received his commission as First Lieutenant in the United States Army Medical Corps and is stationed at Fort Devens, Massachusetts.

Doctor Clifton Scott was appointed acting radiologist at the Middlesex Hospital during the month of August while Doctor Willard Buckley was on vacation. Doctor Bruno Gertsel was appointed acting pathologist during this same period while Doctor Christie McLeod, pathologist, was on vacation.

New London

Doctor Hugh F. Lena, president of the New London County Medical Association, and Mrs. Lena entertained the Board of Trustees and the Board of Censors of that Association at their summer home at Giant's Neck on June 26. Doctor James R. Miller, Chairman of the Council of the State Medical Society, and Doctor Stanley B. Weld, Editor of the *Journal*, were also invited guests. An interesting golf match took place at the New London Country Club in the afternoon, Hartford vs. Norwich-New London. The home team won by a small margin, in no small way contributed to by that final Lena punch which seems to be just as efficacious behind a golf club as on the stump. Mrs. Lena served lobsters and lobsters, but this time the visitors held their own! Doctor Campbell presided at a business meeting which followed the dinner. Those present were Doctors Agnew, Barnum, Campbell, Douglass, E. Henkle, Lena, J. R. Miller, J. F. O'Brien, Satti, Soltz, C. G. Thompson, and Weld. It is such delightful occasions which add pleasure to the routine work of county medical associations.

The annual picnic of the New London City Medical Society was held at Doctor John Satti's home at Oswegotchie on the Niantic River, July 16. A large attendance turned out to enjoy an old fashioned clam bake and athletic events. A light lunch was served at noon. Fishing, swimming, horseshoe pitching, tennis and trap shooting were the attractions in the afternoon. Dinner was served at 6:30 P. M. Prizes in the athletic events were presented with appropriate remarks by the chairman of the picnic committee, Doctor Edward Comstock.

The winners in the athletic events were:

Trap shooting—Doctor Joyce Morris with a perfect score.

Tennis doubles—Doctors Helen Ferguson and John Brosnan.

200 yds. free style swimming race—Doctor Robert Taylor.

Horseshoe pitching contest—Doctor Joseph Becker.

A new interne, James A. Hanaghan of Hartford,

has been named at Uncas-on-the-Thames Hospital for a one year period. A graduate of Trinity College, he completed his medical training at Harvard Medical School this past June.

Doctor Hugh Francis Lena, New London, president of the New London County Medical Association, has been elected a fellow of the International College of Surgeons, according to an announcement from the official assembly being held this week in Mexico City. Doctor Lena is a fellow of the American College of Surgeons, a prerequisite to election to the International College.

Doctor Bryce Smith has accepted an appointment as intern at Uncas-on-the-Thames, having completed a rotating internship at the Albany General Hospital. He is a graduate of Yale Medical School and his home address is New Haven.

News from Yale University School of Medicine

Internship appointments in American hospitals for the fifty members of the Class of 1941 of the Yale School of Medicine have been announced by Dean Francis G. Blake. The appointments to hospitals in Connecticut are as follows:

TO NEW HAVEN HOSPITAL

William R. Bell, of 10 Oakmere Dr., Baldwin, N. Y.—B.S. Rensselaer Polytechnic Institute 1935, M.S. New York University 1937.

Charles B. Cheney, of 36 Morse St., New Haven—B.A. Yale 1934.

Robert F. Dine, of 32 Park Vale Ave., Allston, Mass.—B.A. Harvard 1937.

Horace T. Gardner, Jr., of 127 North Tenth St., Albuquerque, N. M.—B.A. University of New Mexico 1935.

George James, of Ridgefield—B.A. Columbia 1937.

John K. Meneely, Jr., of Coeymans, N. Y.—B.S. Yale 1938.

TO HARTFORD HOSPITAL

Sidney L. Lasell, Jr., of 336 West Bellevue St., Pasadena, Calif.—B.A. Yale 1937.

William Lee, of Madison—B.A. Yale 1936.

Irving Waltman, of 109 Blue Hills Ave., Hartford—B.A. Amherst 1937

TO ST. FRANCIS HOSPITAL, HARTFORD

Louis C. Acquarulo, of 496 Chapel St., New Haven—B.A. Yale 1937

TO MERIDEN HOSPITAL

Thomas S. Harvey, of 349 North Steele Rd., West Hartford—B.S. Yale 1934

THE FORUM

Loss of virility in comparatively young married men has few equals as an upsetter of the applecart. Not only does it affect his own mental and physical well being, but, by creating the suspicion of infidelity, brings discord and disruption to the whole family unit. Yet unless some serious disturbance intervenes, or a wife registers a definite complaint, men are loathe to admit this difficulty. It takes a little tactful detective work to uncover the true state of affairs, and it may be surprising to find how often it ties in with the emotional crises affecting an otherwise peaceful family group.

There is now no doubt that the average case of impotence is due to some psychic maladjustment, fortunately not too involved for the alert family doctor to unravel and treat. It is a rare psychological misfit that needs the expert help of the psychiatrist.

In the ordinary case, the predominant emotional factor is fear motivated by a subconscious sense of guilt. Whether it is financial and business worries, distasteful contraceptive methods, marital incompatibilities and frustrations, dread of earlier indiscretions and excesses, or ignorance and misinformation about normal sex life, the undercurrent is always fear. It is obvious then, that any successful treatment regime will be inadequate unless it is directed primarily toward a neutralization of this factor. To rely on routine injections of testosterone and let it go at that, is only a little more effective than the ministrations of the quack or the mystic pills of the corner druggist. Our job is to work for a permanent cure, for which a much more comprehensive program is required.

The first move in all cases is to interview both husband and wife, singly and together, with repeat performances as needed to gather in all the loose ends. During these conferences, every effort is made to bolster the patient's morale since it is usually at a very low ebb. Assurances are given of an ultimate

cure with speedier results if there is mutual coöperation. Time is also taken out to correct any misinformation about sex, especially that concerning excesses and masturbation. And finally, measures to correct the other contributory factors are discussed. The active phase of treatment is entered only after the basic emotional fault is known and under attack. It must be emphasized that any active treatment is, at best, only a psychological boost and when used alone may be definitely harmful. On the other hand, in its proper place, it has the dramatic effect of tiding the patient over discouraging and depressive episodes by giving him some tangible evidence of improvement.

Of all the measures proposed, there are only three that deserve real consideration. The most important of these is an exercise designed to rehabilitate the perineal muscles. Simple to teach and carry out, it has the added advantage of making the patient an active partner in the cure. The exercise itself is essentially the voluntary contraction of the muscles used in cutting off a fecal column or the urinary stream. An average of 40 repetitions a day is the goal to be reached. Next in importance is a course of 12 prostatic massages. These should be done gently, at weekly intervals, and should include a stripping of the seminal vesicles. As one can readily see, both of these measures are aimed at the supposed seat of the difficulty. But the true value in them reaches farther up since it gives the patient something tangible to grasp.

Last in importance is the use of testosterone, at best considered a temporary stimulant. There is definite evidence that injections of sterile water, activated by a compelling sales talk, will duplicate its results in this condition. If it is used, however, it should be given in the expensive large doses—25 to 50 mgms. at a time and repeated every third or fourth day.

T. P. R., M.D.

Alumni Association of New Haven Hospital House Officers to Meet

The annual dinner for the Alumni Association of the New Haven Hospital House Officers will be held Tuesday evening, September 16, at 6:30 at the New Haven Hospital.

In view of the interest the New Haven Hospital ex-house officers have shown in the past three or four annual dinners, a formal organization was recommended in 1940, and this year Doctors Samuel C.

Harvey, Frederick N. Sperry and John C. Mendillo have drawn up a constitution for this alumni association. This will be submitted to all former members of the New Haven Hospital and staff for their approval. Doctor Sperry will be the first President of this organization, Doctor Harvey the Vice-President and Doctor Mendillo the Secretary-Treasurer.

The speakers for the evening have not been selected as yet. President Sperry is making arrangements for the speaking program.

Irradiation of Bladder and Kidney Tumors

Harper G. Sichler, M.D., of Lansing, Michigan, says in *The Journal of the Michigan State Medical Society* for April, 1941, that most kidney tumors as well as those of the bladder and testicle are radiosensitive and should have preoperative deep x-ray therapy for the double purpose of reducing their bulk and destroying and devitalizing the more sensitive and malignant cellular elements. This makes the removal of large tumors mechanically easier and lessens the danger of metastases resulting from operative trauma. Operation should follow in two or three weeks.

Postoperative radiation is generally advisable. Bladder carcinomata are usually radiosensitive to a moderate degree, and will give a good primary response which will often transform an inoperable growth to an operable one. Tumors of the testicle, especially teratoma testis, are radiosensitive and should always have preoperative x-ray therapy covering the regional gland areas as well as the primary source, followed by simple orchidectomy and postoperative radiation. Carcinoma of the prostate is radioresistant and x-ray therapy is best reserved for the relief of pain.

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LETTERS TO THE EDITOR

To the Editor:

A recent appeal signed by Doctor Thomas Addis, Doctor Max Pinner, Doctor Bela Schick, and Doctor Henry E. Sigerist, tells of one hundred and fifty physicians of the former loyalist Spain who, driven by the civil war from their native land, have at last found refuge in Mexico. For two and a half years they fought fascism in Spain; in concentration camps in France they kept up the struggle. Their devotion to democracy is proved beyond question.

In Mexico they find special need for exactly the services they can best render,—once they have the equipment. Mexican physicians, never too numerous, welcome them. They can be of vital assistance both to their fellow-countrymen from Spain, of whom there are about twelve thousand now in Mexico, and to the Mexicans themselves, who are giving them haven.

They have the plan to establish in Mexico City a sanatorium, a clinic, and a laboratory. A suitable building has been found. Physicians like the stomach specialist, Jaime Pi-Suner, the eye specialist, Manuel Marquez, and the psychiatrist, G. R. Lafara, are on the proposed staff. Nurses, dentists and technicians among the Spanish refugees are eager to give of their skill and knowledge. A committee has been formed to accumulate the equipment necessary to the project and to provide a sustaining fund for its operation.

With this committee the United American Spanish Aid Committee, whose headquarters are at 425 Fourth Avenue, New York City, is coöperating in every way. It is undertaking through its various chapters all over the country the collection of all kinds of medical and surgical instruments and supplies, drug samples, vitamin concentrates, hospital furnishings and other equipment that could be of use to the project.

To the attention of Connecticut physicians the New Haven chapter brings the project with the confidence that they will wish to help and with the hope that in spite of the welter of current demands they will be able to do so.

Further inquiry may be addressed to: Mrs. Hermann Weigand, P. O. Westville, Bethany, Conn.

GREETINGS...

THE NEW HAVEN

DRUGGISTS

ASSOCIATION

PUBLIC AFFAIRS

(Continued from page 704)

When the resolution was pending before the Senate Committee on Appropriations Brigadier General Harry B. McAfee, Assistant to the Surgeon General of the Army stated:

"That change (admitting osteopaths to internship in Army hospitals) defeats the purpose of the interne system in Army hospitals . . . If the provision were extended to include graduates of a school of osteopathy we could not, under our standards, use such graduates in a Medical Corps; and with such an authorization we would be put in the position of training men whom we could not accept in the Regular Medical Corps or in the Reserve Corps."

It is another step on the part of the osteopaths to obtain federal recognition. They are already permitted to render services under the United States Employees Compensation Act.

QUARTO NOTES

A PRIMER FOR DIABETIC PATIENTS. (7th edition.)

By *Russell M. Wilder, M.D., Ph.D., F.A.C.P.*, Professor and Chief of Department of Medicine of the Mayo Foundation, University of Minnesota. *Philadelphia: W. B. Saunders Co.* 1941. 184 pp. \$1.75.

Reviewed by *BURDETTE J. BUCK*

This is the seventh edition of the Primer representing the accumulated experience of the Mayo clinic diabetic school in the treatment of diabetes since 1921. The preface states that the revision is to introduce an improvement in the procedure of administering protamine zinc insulin. The procedure is the administration as a single dose of the proper amounts of protamine zinc insulin and regular insulin (or crystalline zinc insulin). The regular insulin is drawn into the syringe and then the protamine insulin and if administered at once very little mixing or settling occurs. This can be taught the patient readily by demonstration and has been very successful in the diabetic group at the Mayo clinic.

Again the Primer represents the subject matter taught the patient in the diabetic school in Doctor Wilder's clinic. Each chapter is well and simply written and the patient can readily test his degree of proficiency by the questions at the end of each chapter.

From the doctor's view point, several sections are of particular interest. First, the one on insulin and protamine zinc insulin and their administration. This shows the "Wilder" syringe which would be excellent for universal adoption to settle a frequent problem with patients. It also discusses the combined use of regular and protamine insulin and gives excellent rules for regulating their dosages. The second section of particular interest is the one on diabetic complications containing an excellent set of "standing orders for treatment of coma." Section five on other complications presents an excellent discussion of personal hygiene in general and especially of the feet.

This book serves the patient's purpose very well yet could be read with profit by each doctor caring for diabetic patients and the questions at the end of the chapters should not be skipped even by the doctors.

MEDICAL PROGRESS ANNUAL 1940. A Series of Fifty-two Reports Published During 1940 in the New England Journal of Medicine. Managing Editor: *Robert N. Nye, M.D.* Springfield, Ill. *Charles C. Thomas.* 1941 625 pp. \$4.00.

Reviewed by *STANLEY B. WELD*

With fifty-two short concise articles written by as many different experts in the various fields of medicine, the reader has at hand an excellent review of the recent advances in diagnosis and treatment. To the medical student they should serve as a valuable adjunct to his clinical teaching; to the general practitioner, a source of knowledge of the latest developments in medicine; to the specialist, a resumé of advances in fields other than his own.

Of necessity these articles are individualistic in style as well as in content, as, for example, "The Treatment of Juvenile Diabetes Mellitus" by Doctor Allan M. Butler and "Endocrines" by Doctor Joseph C. Aub. Some of the finer aspects are dealt with, as "The Urethral Catheter" by Doctor William C. Quinby, "First-Aid Treatment for Asphyxia" by Doctor Charles C. Lund, and "Allergic Diseases with Special Reference to Histamine and Acetylcholine" by Doctor Francis M. Rackemann. The volume closes with an excellent chapter on "Wartime Preventive Medicine" by Doctor Charles A. Janeway. With one exception all the writers are Boston men, that exception being Doctor Hebbel E. Hoff, associate professor of physiology, Yale University School of Medicine.

There are many typographical errors present in this volume, an unusual criticism for any of Charles C. Thomas' publications. This collection has a real value to the practising physician or surgeon.

SOCIAL SECURITY IN THE UNITED STATES 1941.

A Record of the Fourteenth National Conference on Social Security. *New York: American Association for Social Security, Inc.* 187 pp. \$2.00.

Reviewed by *STANLEY B. WELD*

The main theme of the 14th National Conference on Social Security was social security and the national defense. As in the review of the Thirteenth National Conference on Social Security, so again here it is true that whether or not one agrees with much or little that is printed between the covers of this book it is interesting reading.

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Of particular interest to the medical profession are the papers dealing with medical care and the various plans now in operation or proposed. In the first section of the volume entitled "The Continuing Progress in Old Age Protection" may be found excellent resumé of medical care provisions for Public Assistance recipients in New York City, Baltimore, Chicago, and the "Other City." An entire section of the volume is given over to Medical Care and National Defense. Not only are the problems of medical care relating to national defense dealt with in detail, but there is adequate discussion of the medical program of the Farm Security Administration, of the program of the District of Columbia Group Health Association, of the medical achievements of the Workmen's Benefit Fund, and of medical expense indemnity plans. The paper on this last named subject contains a strong indictment of organized medicine for its opposition to "every major proposal for the creation of a comprehensive health program." Medical expense indemnity plans are branded as a failure because of their costs, the history of voluntary efforts at non-profit medical insurance are considered disappointing, and compulsory health insurance is held up as the only solution of the problem of adequate medical care.

Abraham Epstein, executive secretary of the American Association for Social Security, in his paper on "The Social Security Problems of 1941" calls the reader's attention to the fact that "the nation can benefit greatly by utilizing our existing old age and survivors insurance program to provide also for the dependents and survivors of mobilized men" and thus prevent the political war pension log rolling. As usual, Mr. Epstein holds a brief for compulsory health insurance as a cure for "the greatest cause of poverty—temporary and permanent illness."

To the student of plans for medical care this volume should not be overlooked, bearing in mind always that it represents opinions of a group which is sincere, though biased.

FIRST AID IN EMERGENCIES. (10th edition.) Edited by Eldridge L. Eliason, A.B., M.D., S.C.D., F.A.C.S., Professor of Surgery, University of Pennsylvania School of Medicine; Professor of Surgery, University of Pennsylvania Graduate School of Medicine; Surgeon, University of Pennsylvania, Presbyterian and Philadelphia General Hospitals. Philadelphia, Montreal, and London: J. B. Lippincott Company. 1938. 260 pp. \$1.75.

Reviewed by EDWARD H. CROSBY

This book on "First Aid in Emergencies" is very complete and well indexed for rapid use in case of an emergency. It is so complete that it goes almost beyond the realm of first aid, which is the care of an injured person before the doctor arrives.

The first section entitled "Carriage" shows all possible ways of carrying an injured person and is adequately illustrated with pictures. The sections on bandages and care of wounds are also well illustrated and so complete that this book could be used as a guide in the infirmary of an industrial plant. In the section on fractures, totaling thirty pages, only four pages are used to describe the traction splints for fractures of the arms and legs. I feel that more space could be devoted to the use of traction. The section entitled "Suffocation" explains the Schaefer method of artificial respiration and outlines

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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emergencies due to emersion, gas poisoning, and electric shock. The remaining sections take up plant poisons, medical emergencies and infectious diseases.

In all, the book is an excellent first aid manual which is handy and complete. I do not feel, however, that it could take the place of the "American Red Cross First Aid Manual" which is shorter and is the text book for first aid teaching.

EFFECTIVE LIVING. By C. E. Turner, A.M., S.C.D., DR.P.H. Professor of Biology and Public Health, Massachusetts Institute of Technology; Chairman, Health Section, World Federation of Education Associations, and *Elizabeth McHose*, B.S., M.A., Director of Physical Education for Girls and Chairman of the Health Council, Senior High School, Reading, Pennsylvania. *St. Louis: C. V. Mosby Co.* 1941. 432 pp. 164 illustrations. \$1.90.

Reviewed by STANLEY B. WELD

This is an excellent book. It is intended for youth and should be of particular interest at a time when preventable physical defects are being brought to light through the Selective Service examinations. The volume is attractively bound, with many illustrations to aid the reader, and written in a style easily understood. It is suitable for a text book, since each chapter contains a list of references for supplementary reading. An unusual feature is offered in the form of a self checking list at the close of each unit (or chapter),

providing the student an opportunity to note his progress toward becoming a well-rounded, self directing individual.

The writers have produced a volume full of up to date factual material. Hospital insurance and the effect of sulfanilamide therapy will be found explained within its covers. To many an adult a clearer understanding of what contributes toward producing a useful citizen may be obtained from a careful perusal of "Effective Living."

Physicians may recommend this book without hesitation to any thoughtful student, young or old, who wishes to develop an optimum capacity for living in an age when life is a strenuous experience.

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Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film.

Table of Contents : October 1941

THE PHYSIOLOGICAL EFFECTS OF COLD	Henry G. Barbour, M.D., New Haven	719
LOW TEMPERATURE THERAPY OF MALIGNANCY	Julian B. Herrmann, M.D., New Haven	721
CONNECTICUT'S PART IN THE DEVELOPMENT OF PSYCHIATRY IN AMERICA	C. Charles Burlingame, M.D., Hartford	727
SCARLET FEVER IMMUNIZATION	Clarence G. Thompson, M.D., Norwich	736
OBSERVATIONS UPON THE SIMPLER TECHNIQUE IN SCARLET FEVER IMMUNIZATION	C. L. Thenebe, M.D., Hartford	737
SOME CLINICAL OVERSIGHTS OF SIGNIFICANCE	Marcus Backer, M.D., Bridgeport	741
HELP CONSERVE HEARING	James E. Davis, M.D., Hartford	754
CRIPPLED CHILDREN IN CONNECTICUT	Louis Spekter, M.D., Hartford	755

EDITORIAL

An Editorial by the President	765	The New School of Nursing	767
Meet the Bride and Groom	765	Why Exhume the Midwife?	768
Treatment of Prostatic Hypertrophy with Sex Hormones	766	OCD—The Latest in Defense Planning	769

DEPARTMENTS

ASSOCIATION OF CONNECTICUT JUNIOR	PUBLIC AFFAIRS	781
CLINICS—19TH MEETING	THE FORUM	789
FROM THE SECRETARY'S OFFICE	OUR NEIGHBORS	791
CONNECTICUT HOSPITAL ASSOCIATION	NEWS FROM COUNTY ASSOCIATIONS	793
MEDICAL PREPAREDNESS	QUARTO NOTES (Book Review)	795

MISCELLANEOUS

SPECIAL NOTICES	785	OFFICERS AND COMMITTEE CHAIRMEN
		Connecticut State Medical Society
		Connecticut Hospital Association
		4
		4

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THE PHYSIOLOGICAL EFFECTS OF COLD

HENRY G. BARBOUR, M.D., *New Haven*

The Author. *Trinity 1906. M.D. Johns Hopkins 1910. Research Associate and Professor of Pharmacology, Yale University School of Medicine*

A TABLOID presentation of the physiological effects of cold from the viewpoint of its value in therapy may well begin with mention of four important local uses of cold. These are: 1—in fever, to create a more rapid radiation of heat; 2—to produce local anesthesia. Cold reduces all metabolic processes in cells, according to Van't Hof's Law, by which each ten degree centigrade rise doubles or trebles the rate of chemical and physical processes. The local use of cold in painful tumors gives relief by slowing down the metabolism of the directly chilled tumor cells with their sensory nerve supply; 3—to decrease inflammation; here increased radiation of heat and decreased metabolism of cells both play a part, combined with reflex vaso-constriction which combats edema formation; 4—as a stimulant in psychoses and other conditions. Here a mild jolt to the circulation is afforded by reflex action and the metabolism of deep lying cells is stimulated.

Reflexes such as these contribute to the maintenance of normal body temperature in a cold environment. They result not only in metabolic stimulation but also in peripheral vaso-constriction with reduced peripheral blood flow and anhydremia. Other familiar phenomena occur such as pilomotor action, shivering, huddling and increased cardiac output.

Marked metabolic stimulation, with or without shivering, compensates for heat loss by increasing heat supply; vaso-constriction does this by saving heat. The way in which this is accomplished is that the great reduction in blood flow shifts the steepest part of the heat-loss gradient inwards. From near the skin it removes to a depth, in some localities, of several inches. This diminishes heat loss because the steep gradient must now occupy a much smaller

area. In the words of DuBois¹, the nearly bloodless peripheral tissues become transformed into a "suit of clothes." "Padding" for the "suit of clothes" is supplied by the entrance of extra water into the cells, as has been shown in my laboratory.² This water shift causes some anhydremia, with further heat saving.

Attention should be called in passing to one heat regulating process commonly overlooked. It is possessed not merely by mammals and birds, but by all moist objects. This process is the reduction of the vapor pressure of such objects by cold; thus, evaporation is slowed down and heat loss is less;—a partial automatic regulation against cold which obtains throughout the physical world. Surprisingly, the vapor pressure drops more than 50% upon cooling water from 95° to 75° F. For animals in like environmental circumstances 8% of the heat of metabolism can be thus saved.³

Now the reflexes by which the metabolism is stimulated, the circulation is redistributed and water is shifted, originate in the chilled skin (or blood) and pass through the central nervous system to appropriate end organs. The chief seat of coördination is at the base of the brain, in the hypothalamus. While the posterior hypothalamus is essential to the best protection against cold I have shown that the anterior hypothalamus (which protects against over heating) is necessary for the chief water-shifts of heat regulation.⁴

Some endocrine stimulation is of great importance, the adrenals affording protection by their calorogenic action in acute cooling, and the thyroid similarly in more prolonged cooling, thus promoting acclimatization to cold.

Now a new field for the therapeutic use of cold has been suggested. It demands breaking down the normal heat regulation with forced cooling of all the cells. This unphysiologic process is sometimes

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wrongly described as "hibernation," thus maligning a perfectly normal phenomenon, occurring in a few species. Benedict has attributed hibernation to low normal metabolism with scanty blood distribution in these species. Artificial attempts to decrease the blood temperature of non-hibernating mammals to any extent usually result fatally. For example, Doctor L. M. Woodruff⁵ has found it impossible for dogs to survive blood temperatures of around 80° F. many hours. Chilled humans even may exhibit "livor mortis."

Animals may be made poikilothermious or "cold blooded" by decerebration, with removal of the heat regulating centers, or functionally by anesthesia. Clinicians experimenting with deep-cold therapy use the latter method, of course. Bourne and I have shown that ether narcosis, carried only to the first plane of the third stage, deprives dogs of all power to regulate against extremes of temperature. The curve relating body temperature to environmental temperature acquires a striking linearity.

Recently Doctor J. B. Herrmann⁶ has compared three hypnotic drugs in sub-hypnotic doses and found them effective for breaking down the regulation against cold in rats in the following order: morphine, paraldehyde, nembutal. Since some catatonia occurs with morphine, paraldehyde appears the most appropriate of the three to produce hypothermia. Cooling the body increases the toxicity of these drugs; hence their use requires special caution. Herrmann also finds an antipyretic drug, aspirin, entirely ineffective. It is of much interest that while sensitivity to the group of antipyretic drugs is induced by fever, it does not occur during attempts to cool the body.

Concerning hypothermia the important thing to remember is that to induce it in man it is necessary to eliminate his defenses by a depressant drug. The chilling process increases the toxicity of such drugs. A condition of stupor is produced by the chilling of the brain cells and all function is reduced to an abnormally low level.

Malignancy, drug addiction, psychoses and cardiac insufficiency have all been suggested as suitable for this type of treatment but the results thus far achieved scarcely justify the risks taken.

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University of Louisville School of Medicine Short of Funds

The University of Louisville School of Medicine is the second oldest medical school west of the Alleghanies and the only medical school in Kentucky. It has taken a prominent place in medical history and has attracted to Louisville many illustrious teachers who did pioneer work in American medicine such as Daniel Drake, Samuel D. Gross, Benjamin Silliman and Austin Flint. The school has been running on a very close financial margin for some time, handicapping its faculty and preventing desirable research.

The situation was rendered acute when it was announced a short while ago that the budget for next year would be cut \$3,300, this despite a prospective increase in tax revenue occasioned by the influx of population due to defense industrial work. The dean appealed to Alpha Omega Alpha honorary medical service organization and the society immediately pledged its entire financial resources as well as the active efforts of its members. In an effort to establish a permanent endowment fund a plea was broadcast to some 5,000 medical school alumni to participate. The graduating class backed the drive with a substantial collective gift, supplemented by individual pledges. This is the first time the University of Louisville School of Medicine has been obliged to go out among its alumni for funds for current expenses.

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LOW TEMPERATURE THERAPY OF MALIGNANCY

JULIAN B. HERRMANN, M.D., *New Haven*

The Author. PH.B. *Sheffield Scientific School, 1917*;
M. D. *Yale Medical School, 1921. Research Assistant,*
Department of Pharmacology Yale Medical School;
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pital, New York

THE term "hibernation" has recently been applied to a new, low temperature therapeutic procedure for the treatment of malignancy by Fay and Smith who devised the method. The choice of the term is unfortunate since hibernation is a normal, physiological process for a number of species while the procedure used for treating malignancy is far from that. Crymotherapy, or cold treatment, is the more accurate and descriptive terminology used by other clinics for this type of therapy. Since the term "hibernation" is being employed so loosely, a few remarks on this physiological phenomenon might be of interest.

For over a hundred years controversy has raged on the cause and meaning of hibernation in animals. What causes the animal suddenly to undergo a transformation from the warm-blooded (homeothermal) type to the cold-blooded (poikilothermal) type?

Blandet (1864) came to the conclusion that winter-sleep was a relic of the times when winters were so severe and food so scarce that the animals, in order to survive, were forced to enter this state.

Merzbacher and Polimanti believed that at some remote period all animals periodically fell into lethargy. With evolutionary development most mammals and birds lost this ability but hibernating animals are still able to return to the cold-blooded type when the heat-regulating reflexes fail under extreme cold. Human infants exhibit this poor heat-regulating mechanism demonstrating the phylogenetic evolution of man's thermal regulation. Thus hibernating animals merely revert to a more primitive type in which there is no specific sensibility to outside cold, i.e., in which no specific heat-regulating reflexes are called forth by the external temperature.

Marshall Hall (1832) believed that hibernation is a form of sleep differing from ordinary sleep only in degree. This view is shared by many present day

students of the subject. Hall believed that the cold caused ordinary sleep during which there is diminished respiration and less heat production. The lessened respiration causes the blood to lose its arterial character, hence its power to stimulate the heart. The heart, however, changes its irritability so that it does not stop. This change in the irritability of the heart he believed to be the important factor in hibernation.

Other investigators have associated hibernation with the nervous system. Thus Claude Bernard thought that cold acts on a well developed peripheral nervous system to slow respiration, and in this way cools the body. This results in a loss of stimulus to the heart and muscles with consequent torpor.

Marès and Hellich reasoned that if hibernation is associated with the nervous system it ought to be possible to reduce body temperature by hypnotic suggestion. They hypnotized three subjects reducing the mouth temperature to 33° C. in one case while in the others the reduction varied from 1.5° C. to 2.5° C. and persisted for several hours. On being released from the trance the temperature returned to normal. In one case the temperature, after being lowered 2.5° C., was raised 2.6° C. above normal by suggestion.

The Hindu fakirs may use this method of autohypnosis to go into a state of suspended animation which is not unlike hibernation in some respects.

The first attempt to produce generalized subnormal body temperature as a therapeutic procedure was made by Fay in 1936. While investigating body temperatures from the standpoint of neurological segments he was impressed by the constant finding of a much higher surface temperature over the breast than over other segments above and below. Further consideration of the subject revealed the fact that malignancy occurred most frequently in those localities in which the temperature was normally higher such as the uterus, breast and gastro-intestinal tract. Between mouth temperature and surface temperature of the extremities there might be a variation of 6° F. to 20° F. Furthermore, as Geschicter and Copeland showed, metastases occur predominantly in those segmental areas of highest body temperature while those areas of lower temperature such as the

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extremities very rarely show primary or metastatic lesions. In a series of one hundred cases they found no metastases to the ulna, fibula, patella or bones of hand and foot.

The statistics of Coley and Higinbotham also demonstrate that primary and metastatic malignancy of the bones in the hands and feet are rare. Likewise Mason showed that carcinomas of the hands and feet are uncommon and usually of a low-grade malignancy, while Charache makes a similar observation placing the occurrence at 1% of all carcinoma in different parts of the body.

Other evidence that temperature is an important factor in normal cell growth is adduced from the work of Huggins and Noonan. They showed that the red marrow present in the tail segments and metatarsal bones of newborn rats normally disappeared from these locations in about two weeks if the animals were exposed to temperatures lower than that of their bodies. If, however, the distal part of the tail was implanted in the abdomen or back, or if the feet were amputated and placed in the abdominal cavity the red bone marrow persisted. The red marrow of the portion of tail left exposed to the surrounding temperature was replaced by yellow marrow. Further, it was found that in young rats reared in a temperature of 95° F. the red marrow persisted in the tail and small bones of the extremities.

Finally Smith produced developmental abnormalities in chicks which were incubated at 90° F. to 93° F. Even if the chicks were exposed to this temperature for 48-72 hours and subsequently incubated at 103° F. for the remainder of the normal incubation period of twenty-one days they showed one hundred per cent of developmental defects.

Procedure For Inducing "Hibernation." The procedure for inducing so-called hibernation has been set forth in detail by Fay, Gerster and others so it will suffice merely to emphasize a few points. Most important it is to understand that the treatment is highly technical and must be carried out with suitable apparatus and specially trained personnel. The patient is put to sleep with avertin or one of the barbiturates administered either rectally or intravenously. After being placed naked in an air conditioned room whose temperature is maintained at 55° F. he is surrounded by cracked ice. Temperatures are read from a thermo-couple inserted in the rectum. When the rectal temperature drops to 90° F., which usually takes from 1½-2½ hours, the

ice is removed. It continues to drop to about 86° F. to 83° F. and is maintained at that level by application of warm blankets and hot water bottles if it goes lower or the reapplication of ice if it goes higher.

Two ounces of normal saline with 10% glucose is given by stomach tube every hour and amylal, seconal or sodium luminal for restlessness.

When it is time to discontinue the treatment the air conditioning apparatus is stopped and the patient covered with warm blankets. In about six to eight hours the body temperature has returned to normal.

It is seen that in every instance the patient was rendered unconscious by a drug before being subjected to the low environmental temperature. Large doses of the hypnotics, by disrupting the heat-regulatory mechanism, cause a drop in body temperature in the unconscious individual exposed to a cold environment. What effect do small, non-narcotizing doses of hypnotic drugs have on the mechanism of temperature reduction? To elucidate this point I experimented on rats with a number of hypnotic drugs, namely, nembutal, morphine, and paraldehyde.* In addition aspirin, whose antipyretic property is so well known, was investigated.

In my work I used very small doses of the hypnotic drugs—so small that they caused no discernable depression. However, when these animals were placed in a cold environment there was a marked drop in body temperature which was not exhibited by undrugged controls exposed to the same temperature. It was interesting to find that aspirin, which is a drug par excellence for reducing hyperpyrexia, had no effect on the temperature of normal animals exposed to cold. Another finding of interest and practical importance was that nembutal and paraldehyde are much more toxic in rats at low environmental temperatures than at ordinary room temperature.

Thus in order to reduce body temperature by exposure to cold it is necessary to make the individual poikilothermous. This may be accomplished by inhibiting the action of the central heat-regulatory mechanism through the use of drugs. With the heat-regulatory apparatus intact the individual resists strenuously all attempts to reduce the body temperature. The important mechanisms by which temperature homeostasis is effected are shivering, vascular phenomena, changes in metabolic rate and

*To be published.

body water shift.

Several days may elapse after the patient has been returned to room temperature before the heat-regulatory mechanism begins to function normally. During this period the temperature may run from 100° F. to 101.5° F.

Although only inoperable cases and those in the terminal phases of malignancy are selected for treatment, not all patients are suitable for this type of therapy. The contraindications to its use are as follows:

Bed ridden patients who are too weak and have but a brief life expectation.

Marked anaemia (hemoglobin less than 60%). Necrosis of vulva or buccal mucous membrane may ensue.

Carcinoma of stomach. Fluids and sedatives may not be absorbed.

Lung metastases. Increase the danger of pneumonia.

Pathological fracture of femur. Splints and casts hazardous due to reduced peripheral circulation.

PHYSIOLOGICAL EFFECTS

Cardio Vascular System. After an initial rise the pulse rate is decreased but not in proportion to the temperature. In a series of six cases reported by Vaughn it did not drop below 70 even in a case where the body temperature was reduced to 83.2° F. Irregularities of the pulse are frequent and generally due to sinus arrhythmia or auricular fibrillation.

The blood pressure varies. During the induction of "hibernation" there may be a rise in the systolic pressure, diastolic pressure or both. Sometimes an epinephrine effect is observed, that is a rising diastolic and falling systolic pressure. As a rule both show a considerable decrease after long exposures while with a short exposure there may be no appreciable change. Often the auscultatory method is unsuccessful probably because of vascular constriction and, as Smith and Fay have shown, slowed circulatory rate and blood flow. This vascular constriction is profound, large arteries such as the radial, posterior tibial or dorsalis pedis may be impalpable at low temperatures. The veins likewise are collapsed making venipuncture difficult.

The most frequent electrocardiographic abnormalities are changes in the Q-T interval and abnormality of the T wave. The lengthening of the electrical systole is probably due to the damage of the heart by cold rather than a simple chemical retarda-

tion from cold since determinations of serum calcium and phosphorus concentrations show no significant change. As was stated previously, change in the irritability of the heart was thought by Marshall Hall to be the important factor in hibernation.

Hematology and Blood Chemistry. During the treatment there is an increase in the hemoglobin, r.b.c. and w.b.c. with a rise in the polymorphnuclears and a shift to the left. Most of this increase in cell count is probably relative, due to a concentration of the blood. There is a decrease in platelets and sedimentation rate, the latter returning to pretreatment level in about forty-eight hours. The red cell volume in some cases increases from 14-20%. In the course of longer periods of treatment there is a drop in the hemoglobin, red count and cell volume.

Striking leucocytoses were reported by one observer within the first 24-48 hours, as high as 50,000 but usually from 15,000-20,000 with very little change in the differential, the count dropping promptly within 24-48 hours after the temperature has returned to normal. This may be due to a constriction of the smooth muscle of the spleen caused by the cold, similar to the leucocytosis which follows pilocarpine, muscarine or barium and ascribed to the same splenic phenomenon.

The blood chemistry findings vary with different observers. Thus Bernhard found an increase of the non-protein nitrogenous constituents in two out of eleven cases with no change in the other nine while others report a drop in urea. There were no changes in plasma chlorides, or plasma protein. The changes in serum calcium and phosphorus were not significant while the serum cholesterol partition showed the percentage of free cholesterol to be relatively constant. No figures are given except for the urea.

Vaughn gives figures for six cases showing a slight increase in blood sugar and chlorides with a decrease in the non protein nitrogen and urea.

Smith and Fay found a drop in urea particularly in cases where fluid balance was maintained. They say that a tendency toward reduction of chlorides and blood sugar and a rise in carbon dioxide could be prevented by the introduction of glucose and saline to maintain fluid balance.

These discrepancies are due to the changes in blood concentration at low temperatures. The figures given by the various authors are relative. In no case have the estimations been made on an absolute basis, that is, taking into account the general blood concentration at the time.

Basal Metabolic Rate. All observers are in agreement that there is a definite drop in the metabolic rate of individuals with continued low body temperature. There may be a slight increase in the initial stage of cooling which is probably due to shivering and other physiological mechanisms by which the organism attempts to produce temperature homeostasis. The metabolic rate quickly returns to the preliminary level when the body temperature becomes normal. The decrease in the blood urea reported by the majority of the observers can be explained on the basis of decreased metabolism with consequent diminished formation of waste nitrogenous products.

EFFECT OF LOW BODY TEMPERATURE ON NEOPLASMS

Results of Local Cooling. The low body temperature may be local or general. Fay and Smith have used the term refrigeration to designate the first type and hibernation for the second.

Refrigeration or the local application of cold is not a new therapeutic device in the treatment of malignancy. Superficial cancer (rodent ulcer) was treated with carbon dioxide snow by Morton in 1912 and Graham Little in 1915. Ethyl chloride was applied by Howitz of Copenhagen who recommended freezing of surface cancer as far back as 1901.

In the recent attempts to treat neoplasm by cold, refrigeration has given the most striking results. It has been tried with favorable results on various neoplastic conditions which are accessible for this type of therapy such as inoperable carcinoma of cervix, prostate, bladder, breast, and superficial metastases. Circulating water at a temperature of 40°–50° F. is brought in contact with the lesion by means of a closed circuit. Within 24–48 hours there is a marked regression in the size of the lesion with a concomitant diminution of pain. This may progress in some cases to the complete disappearance of the lesion or healing of a fistulous tract. Biopsy specimens taken at intervals from these lesions show continuous regressive changes.

During the initial decrease in size, microscopically the lesion appears to be diminishing largely because of a reduction in the blood supply resulting from a persistent ischemia caused by the continuous cold. It is difficult to recognize vessels because they are so constricted and contain so few red cells.

As time goes on microscopic sections show increasing degenerative changes. There are variations in the staining capacity of the tumor cells with

swelling and granular changes in the cytoplasm, and loss of nuclear and chromatin detail. These changes progress with the ultimate production of cellular necrosis followed by liquifaction and absorption. At this stage there is a disappearance of the necrotic tumor tissue.

These cytologic changes in the tumor cells are in many respects comparable to those seen after radiation therapy, i.e., nuclear destruction and cytoplasmic disintegration. However, there is one striking difference. Irradiation destroys normal tissue, including smaller blood vessels, as well as cancer cells so that healing gives a dense avascular scar. But 40° F. local cold, even for as long as five months consecutively, causes no damage to skin or supportive tissues, according to Smith, so that repair takes place without scar; i.e., there is a normal regenerative process. Also 40° F. to 50° F. is bacteriostatic for both common saprophytes and ordinary pathogens and this may account in some measure for a reparative process without scar and for a lack of foul-smelling discharge.

Following the disappearance of the lesions there is a marked retardation in recurrences. Furthermore, the rate of growth during recurrences is definitely diminished.

Many years ago Juliusberg described the histological changes in skin which had been frozen with carbon dioxide. He demonstrated that if normal skin is frozen and then immediately excised, sections of it show no pathological changes except thrombosis of the cutaneous vessels. If, however, normal skin is frozen hard for thirty seconds and excised fourteen hours afterwards sections show a similar thrombosis of the blood vessels, the thrombi being either hyaline or composed of leucocytes, erythrocytes or both. Around the vessels is a well marked infiltration of leucocytes. The lymphatics are dilated and filled with coagulated, homogeneous masses. Such sections show, however, the most marked changes in the epithelial layer, the cells of which appear structureless and homogeneous, the nuclei clear and, with the exception of some nuclei of the basal layer, do not stain. Beneath the epithelium he described a layer of large polynuclear leucocytes which also infiltrate the connective tissue, while the connective tissue cells are swollen and hypertrophied. The elastic fibers are unchanged but, if the section is stained with Weight's fibrin stain, the whole connective tissue layer is found to be full of fine strands of fibrin.

This description is essentially the same as that given by the recent investigators. It would appear that the cellular destruction is not due to the action of cold on the cells but to the devitalization of the cells caused by thrombosis of the vessels supplying the area. Further evidence that cold itself does not destroy neoplastic tissue is contributed by Ehrlich and the later work of Breedis and Furth. These investigators showed that various types of mouse neoplasms could be kept at temperatures as low as -70° C. for intervals varying from a week to one and a half years and at the end of that time if thawed and injected into mice the tumor would grow.

Results of General Cooling. The consensus of opinion of those who have tried this method is that the only beneficial result of any consequence is an alleviation of pain. The extent and duration of this phenomenon is variable, ranging from no relief at all through short intervals of diminution or cessation (24-48 hours) up to several weeks and even months in a few cases. One clinic reports a group of 24 cases in which five or 20.8% had no pain to start with, eight or 33.3% obtained little or no relief of pain, and eleven or 45.8% experienced marked relief of pain. On analyzing the same series, taking only the cases with pain at the onset of treatment, 19 cases in all, eight or 42.1% had no relief from pain while 57.9% experienced marked relief. However, in these latter cases the benefit was only transient, pain recurring in all cases—in some within 24 hours but in one case not until after the lapse of eight weeks. Other clinics have reported isolated cases in which no narcotics were necessary for as long as several months after treatment. Pain may be present for the first 24 hours after regaining consciousness and may disappear during the second 24.

No decrease in size of primary or metastatic lesions in soft tissues were noticed by the Lennox Hill group; on the contrary these lesions were often larger at the end of the treatment. Bone metastases likewise did not regress but frequently were found to be larger in subsequent examinations.

The report of the pathologist at Lennox Hill was as follows:

"We did not find any regression of the primary tumors or metastases, nor were we able to demonstrate unusual cell alterations or any changes which could be interpreted as effects of cryotherapy on the neoplastic tissue. Nothing characteristic or uniform was found except perhaps the acute inflamma-

tory lesions of the pancreas which occurred in three of the five cases of carcinoma."

This is not surprising. As a matter of fact it is what experimental work in this field would lead one to expect. As has been shown above a variety of mouse neoplastic cells are able to withstand exceedingly low temperatures, much lower by far than those to which the human body was exposed either locally or generally. Further, Bischoff has reduced the body temperature of mice inoculated with sarcoma below 20° C. for seven hour periods on five successive days and in other cases for 24 hour periods, producing a condition resembling "hibernation" with no permanent effect upon the growth process of the neoplasm.

Discussion. In so-called hibernation the action of the cold in alleviating pain is not on the lesions themselves or on the sensory nerves to a great extent but chiefly on the cerebral cortex. During the treatment the patient, though semiconscious, will answer questions correctly but after treatment is terminated and consciousness is restored there is complete amnesia for the treatment period. This is probably due to a combination of the hypnotic drugs and the cold.

The injury to the cerebral cortex manifests itself during the first 24-48 hours after emergence by more or less haziness of the sensorium. Several cases which died within a short time after completion of the treatment revealed at autopsy a cerebral oedema. Smith, believing that the barbiturates are a factor in the production of the oedema, has discontinued their use. The barbiturates may cause the cerebral oedema but another possible explanation is that at low temperatures their increased toxicity contributes to the death of the individual, the oedema being the result of damage to the brain by the cold. Bender reports the autopsy findings of a man who was frozen to death in a storm. The brain was congested and contained miliary hemorrhages. Microscopically the nerve cells showed severe vacuolization.

After cessation of exposure to low temperature, injury to the cells of the cerebral cortex is soon repaired and with the reparative process comes resumption of function and return of the pain sensation. Depending on the extent of damage done to the brain nerve cells is the magnitude and duration of the relief from pain.

The best results obtained by general cooling gave transient relief of pain to a greater or lesser extent in but 60% of the cases treated. Considerably better

results can be obtained by orthodox methods with much less risk. The "hibernation" procedure is expensive, cumbersome, and not without danger even in expert hands and under ideal conditions. There is always the constant threat of pneumonia although routine nose and throat cultures for pneumococci and hemolytic streptococci before treatment tend to minimize but do not eliminate this complication. In addition, the slowing of the circulatory rate and the increase in viscosity and concentration of the blood at low temperatures predispose to the formation of thrombi and emboli. One death was reported from this cause and another from circulatory collapse associated with the cardiac injury from the low temperature. In a series reported by Smith, five cases died of cardiac failure within 24-48 hours after general cooling. In each of these cases autopsy revealed extensive myocardial degeneration.

Excellent results in the control of pain may be obtained by the judicious use of drugs. Unfortunately it is the practice with many to administer morphine indiscriminately from the onset in cancer cases on the basis that the condition is incurable and the patient might as well have the benefits of morphine since habit formation is no longer a cogent factor. Under this regimen a tolerance is rapidly developed leading to a state of anorexia with inanition, rapid loss of ground and no relief from pain. If these cases are given salicylates and codeine in the early stages it is surprising and gratifying to see how long they can be kept comfortable and in relatively good condition before it is necessary to resort to morphine.

When the drugs no longer suffice more drastic procedures such as alcohol injection of nerves and the introduction of alcohol intraspinaly will give as good results as "hibernation" with less danger and need for the highly specialized personnel and expensive equipment that the latter entails. Finally chordotomy may be used if all other measures fail. In most instances the patient has died from cachexia before this state is reached.

Conclusion. Although the most spectacular results are obtained with local cooling the practical importance is not great. In superficial ulcerating and necrotic malignant lesions the pain is due not so much to the malignancy as to the infected, necrotic and sloughing tissue. Cultures of these lesions show a mixed infection with a variety of organisms. If these lesions are cleaned up and the bacteria de-

stroyed, the odor and pain disappear. Recent work by Freeman shows that this result may be readily achieved by the use of zinc peroxide paste.

While "hibernation" opens new avenues for the investigation of the physiological effects of low temperature on the human organism its value as a therapeutic agent in malignancy or its superiority to orthodox methods for the control of pain has not yet been proven. The benefits are not commensurate with the danger and expense involved in such a highly technical procedure—one which requires a large staff in an institution or expensive apparatus at home. The judicious use of drugs at home by the family physician will give results as satisfactory as "hibernation" in the vast majority of cases while alcohol injections suffice in the more recalcitrant. "Hibernation" as a therapeutic device in cancer has very little to offer the patient over the orthodox forms of treatment.

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CONNECTICUT'S PART IN THE DEVELOPMENT OF PSYCHIATRY IN AMERICA

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OUR STORY begins in the latter part of the eighteenth century with a boy, a flute, a fiddle and a tiger all of which played an important part in the beginning of a movement which was to completely alter the treatment of the mentally ill in this country. The boy was Eli Todd the son of a New Haven merchant, and it was he who was destined to bring to the medical profession a new and sound type of thinking in regard to the nature, cause and treatment of the mentally ill.

Following his graduation with honors from Yale College it was decided that the young Todd should broaden his education by means of foreign travel, but he had progressed only as far as Trinidad in the West Indies when the dread yellow fever came close to ending his career. This was in the year 1787. For days he was alternately counted lost or saved, but eventually youth triumphed and then followed a long period of convalescence when, with his flute or violin, or both, he often went to the beautiful public parks where one of the prize exhibits in the Zoo was a recently arrived tiger. The snarling, clawing, plunging, terrifying acts of this jungle beast held him spell-bound at a time when he himself had just been released from the torments of delirium and the long enforced restraint of the sick room. At the first few notes from his flute the boy noticed the tiger's increased violence and he decided to experiment. The following day he played again, but this time out of sight of the tiger. By the third day he had observed that the music of his flute and his violin had a tranquilizing effect upon the animal fresh from the jungle.

These observations and the lesson he drew from them never left Eli Todd. From that day he became a profound student of human beings and animals, and the emotions and factors which influenced their behaviour. Never was he to forget the feelings of a person or animal who by reason of sickness was deprived of liberty or freedom of action. It was in those hours when he sat thinking over his own recent experiences, observing the reactions of the tiger, that he began his lifelong study of the amelioration of the suffering which comes through enforced restraint and confinement.

He was hardly home from Trinidad when another misfortune played its part in the development of his understanding and powers of penetration into human emotions. His father, Captain Michael Todd, had left a substantial fortune to his boys, all of which was in the hands of an elder brother. However, the brother and most of the fortune were lost at sea, leaving young Todd but a fraction of his original inheritance.

With his interest in human welfare, it was logical that Todd should turn to medicine as a career and a livelihood, and so, according to the practice of the day, he apprenticed himself to Doctor Ebenezer Beardsley, of New Haven, who undertook to qualify him for the practice of physick. The then

full allotted time of two years' apprenticeship passed quickly and the young doctor, no longer a neophyte, embarked upon his medical career in Farmington, Connecticut.

Todd had been taught to think and he was inclined to question all things he observed. He identified himself neither with the then popular Cullen School of blood-letters and depleters nor with the Brown School of stimulants, with their Spanish fly and brandy, although he favored the latter. Through his readings he had been influenced by the kindly Doctor Herman Boerhaave of Leyden University for whose position and leadership in the medical world Cullen and Brown were striving. Above all, Boerhaave had called upon his pupils to "observe and think beside the sick bed." This fitted in with young Todd's own inclinations and his experience in Trinidad, and never did he cease to think and observe beside the sick bed.

In 1763, six years before Todd was born, a group of Connecticut doctors had petitioned the Legislature for a charter that would distinguish the "honest and ingenuous" physician from the "quack." Accusations of attempting to establish a grasping monopoly and trample upon the sacred rights of the individual were hurled at these early champions of sound and ethical medicine, principally by those for whom it was designed. Quacks were flourishing; the new frontier country was having its medical gold rush; charlatans, soothsayers and patent-medicine equivalents were in conflict, each group doing its best to out-do the other. But they found a common cause in fighting this early effort to make them conform to some standards for the protection of the patient. The Legislature's denial of a charter for a medical society with power to regulate practice did not discourage the group of New Haven doctors who formed the New Haven County Medical Society. This Society was well under way and exerting great influence when young Todd, in his first year as a Farmington physician, formed the Society of Medical Friends. These two societies were forerunners of the Connecticut State Medical Society.

With the passing years Todd grew in cultural and professional stature, as did his human understanding and consideration for those less fortunate. He moved to Hartford, then a growing commercial town of six or seven thousand inhabitants, which dealt in lumber, smelled of molasses and old Jamaica rum, and still enjoyed trade with the West Indies despite the embargo. Hartford at that time shared with New Haven the honor of being the capital city for six months out of each year. Mason Fitch Cogswell, of the Society of Medical Friends, was serving the eighth of his ten terms as President of the Connecticut Medical Society. This group had become extremely active, and through its control of license and honorary degrees had brought about an orderly practice of the profession. Charlatanism was having a hard time; Todd was in his early fifties; it was December, 1820; the Hartford Medical Society, the local branch of the State body, was meeting in the old Hartford Hotel; the Secretary recorded among those present, Woodward of Wethersfield, Bestor of Simsbury, Everest of Canton, Cogswell, Todd and young George Sumner of Hartford. The story goes that "they were long at the dinner table, drank a moderate amount of wine and

listened to a multitude of stories," but Todd had chosen this as the occasion to launch a program which had been maturing in his mind for many years. He rose to his feet for the business of the evening.

"The people of New England," he began, "inherit the constitution of their ancestors and partake to a greater or less extent of their hereditary disorders. One of these, and by no means the least considerable, is insanity. But other causes here operate with peculiar force. The easy transition from one rank of society to another, and the facility with which wealth is accumulated, serve to cherish even in humble life those hopes which in other countries are repressed or entirely subdued. Expectations high raised are the usual precursors of disappointment, and numerous cases of insanity have thus been produced.

"The situation of the unfortunate victims of insanity—beings enslaved by the phantoms of their own imagination—is wretched in the extreme. In intercourse with society their spirits are wounded and the anxious countenances of their families serve but to depress hearts already overloaded with sorrow. Some of these unfortunates are doomed to a confinement that should be reserved for guilt alone, and consider the wretchedness of those families upon whom devolve the care and maintenance of these saddened sufferers. Their peace is interrupted, their cares are multiplied, their time is engrossed and their fortunes reduced. The misery which they suffer is communicated to an extensive circle of friends and the whole neighborhood is indirectly disturbed by the malady of one."

Todd then described the history of insanity:—"In ancient Egypt the insane were conducted to those temples in which were collected whatever seemed calculated to please the eye and rivet the attention. There, as they wandered from one magnificent object to another, the world and its vexations were forgotten and the gloomy images which haunted them were banished from their minds. In Greece, on the other hand, the followers of Hippocrates relied exclusively on the specific powers of Hellebore and its adjuvants, medicines which at this day are rarely employed." The speaker then continued to picture the dark days of the Middle Ages when insanity became confused with witchcraft, sorcery, demonology and heresy and its victims, meeting with the same fate, were chained in dungeons or burned at the stake. With dramatic intensity he described the incident of Phillipe Pinel's visit to the miserable sufferers in the Bicêtre Hospital in 1792 when he struck off their fetters to demonstrate to the world they were sick people and should not be chained as wild beasts. This action of Pinel had awakened interest in England where, until shortly before, curious crowds had been permitted, for a fee, to witness the morbid sights of old Bethlehem Hospital, better known as Bedlam. Then in May, 1796, the British Society of Friends, under the leadership of William Tuke, had opened a refuge near York which they called The Retreat.

"The history and ceremony of the Retreat of York," said Todd, "may be consulted with equal pleasure and advantage. It furnishes a lucid view of the effect of moral management and teaches how much may be accomplished by the perseverance and the charity of the few. Its managers appear, how-

ever, to have placed too little reliance upon the efficacy of medicine." Todd proceeded to describe the type of institution he favored:—

"Such an asylum should be the reverse of everything which usually enters into our conceptions of a mad-house. It should not be a jail in which for individual and public security the unfortunate are confined, nor should it be merely a hospital where they may have the benefit of medical treatment—for without moral management the most judicious course of medication is rarely successful—, nor should it be merely a school where the mind is subjected to discipline while the body continues to suffer in consequence of original or symptomatic disease."

Thus, it was on this evening in December, 1820, over one hundred and twenty years ago, that Eli Todd stepped far in advance of his time when he urged that insanity should come under the supervision of medicine, stating that it was only a manifestation of disease. Stressing the word disease, Todd exclaimed:—

"Gentlemen, I am convinced that mental disorder is as definitely a manifestation of disease as is a fever or a fracture. It is our duty as civilized men to attack this disease. Let us make diligent inquiry, find out how prevalent this disease is, and then establish an institution for its treatment and cure. I move you that we instruct our delegates to the next State Medical Convention to urge upon the profession throughout the State the propriety of taking steps to establish such an institution."

The State Medical Convention met in Hartford in May of 1821. Once before, in 1812, the Reverend Nathaniel Dwight, M.D., both preacher and practitioner of medicine, had presented a similar matter to the convention to no avail. This time, however, Todd's vision for an institution brought not only enthusiastic endorsement but an appropriation of two hundred dollars, then a sizeable amount, from the Society treasury for a survey of the needs. The following October the committee reported that approximately one thousand deranged individuals in the State of Connecticut were being cared for, often under conditions unbelievably barbarous. Then, as now, the Connecticut Medical Society felt and assumed a definite responsibility for individual and public health, and they emptied their treasury for the cause. A relief society was formed with sub-committees in every county in the State, the doctors joining with the outstanding clerics, business men, lawyers and society leaders in every county. For two dollars a year the giver became a member; one hundred dollars and he became a director for life; two hundred dollars and he became a life-long vice president. The two-dollar memberships annually elected the same number of directors as were holding office by virtue of their one hundred dollar contributions. Donations ranging from twelve and a half cents to three hundred dollars were gathered in throughout Connecticut, Maine, Rhode Island, Vermont and Massachusetts. Nor was money the only contribution, for among the non-monetary gifts recorded there appears "one gross of New London Bilious Pills, market price \$30.00."

By May, 1822, twelve thousand dollars had been paid in on pledges toward the proposed institution, and "The Retreat" had been chosen as its

name. Later that month Todd received the following satisfying message from General Nathan Johnson, Hartford's representative in the Legislature who had presented the Medical Society's petition for a charter:

"New Haven, May 22nd, 1822

"I have just marched from the battlefield in full triumph. Today, after a long and animated debate, the petition was granted—\$5,000 from the Treasury and a brief for five years for liberty to solicit public contributions."

By October of 1822 twenty thousand dollars had been subscribed, Hartford had been selected as a location, and "a place one and a quarter miles southwest of the city, fifteen acres of land, a house, two barns, crib and cider mill, price \$2400" had been purchased as the site. There the institution remains to this day with the acreage increased.

At a considerable financial sacrifice to himself, Eli Todd was unanimously chosen as the medical head. The first patient was admitted on April 1, 1824, and it may be said that this Connecticut group followed policies and paths that no man nor institution in America had previously trod, ran counter to the teachings of such contemporary medical giants as Benjamin Rush, disputed Rush's theories with all the conviction of their sincere belief, and denounced such methods of treatment as "pouring cold water into the coat sleeves, privation of food and, if all these modes of punishment fail of their intended effect, resorting to the fear of death."

It took no little courage to oppose these teachings of ^{the} great Rush who, claiming that "the cause of madness is seated primarily in the blood vessels of the brain," also cut, bled and blistered his patients as a means of restoring their reason. At that time Rush's methods had been accepted as a great step toward humanitarian treatment of the insane—as indeed they were, against the background of Salem witchcraft burnings together with whips and chains for the insane—but this advocacy of venesection, terror, deception and punishment found no place at the Connecticut Medical Society's Retreat, nor with its Superintendent.

A committee of the Connecticut Medical Society, styled the Medical Visitors to the Retreat, decided to define Connecticut's new and original conception of the care of the insane, and, in its third official report, issued in 1827, are passages which stand out against the then prevailing medical practices and beliefs set forth in Rush's book "Diseases of the Mind," published a year before his death. In a preamble to this report of the Medical Visitors it is stated:—

"As the general plan of treatment adopted in this institution is more or less original, and differs from that pursued in any other hospital, the Committee are bound to give a brief detail . . . the first business of the physician is *to gain the entire confidence of the patient*. With this view, the patient is treated with the greatest kindness, however violent his conduct may be,—to understand, if he is capable of reflection, that so far from arriving at a madhouse, where he is to be confined, he has come to a pleasant and peaceful residence, where all kindness and attention will be shown him and where every means will be employed for his health. In case coercion and

confinement become necessary, it is impressed upon his mind that this is *not done for the purpose of punishment* but for his own safety and that of his keepers. *In no case is deception of the patient employed, or allowed,—on the contrary the greatest frankness, as well as kindness, forms a part of the moral treatment.* His case is explained to him, and he is made to understand why the treatment to which he is subjected has become necessary.”

To this should be added the following quotations from Todd’s writings of more than one hundred years ago, which might have been written today as describing the beliefs at the Retreat, now popularly referred to as The Institute of Living:—

“It is by no means intended to exclude the aid of medicine. For, as before observed, the mind and body are so connected that there can scarcely be a disease of either in which the other is not involved, and in which medicine and moral treatment may not be advantageously combined. When mental derangement originates entirely in a diseased state of the body—medication constitutes the paramount, and moral treatment the subsidiary means of cure. On the other hand, when bodily disease is merely the effect of mental derangement, then there is a complete inversion of the relative importance of these curative means. In most states of insanity, therefore, a judicious combination of both promises the most successful results.”

But the new institution and this newest branch of medical knowledge were none too secure with the completion of the first building and the admission of the first patients. Finances were then, as always, a serious question, and so the second year of its existence found the institution possessed of legislative permission to conduct a lottery as a means of raising funds. This netted some \$7,000, and later the lottery rights were sold to another for \$10,000 with which fund the institution was enlarged. This was a sizeable sum when one takes into consideration that Connecticut patients were received at \$3 a week and out-of-State cases at \$3.50 a week.

Ranking ninth in the heavy expenses of operation was the cost of wine and spirits for patients use as well as for personnel. Narcotics were used sparingly, and treatment included “wine and foaming tankards of beer,” although Todd sponsored an association to make it “unfashionable, uncivil and gross to offer . . . friends ardent spirits of any sort.” The cogitations of Todd and his friends on the subject of alcohol make interesting reading when it is considered that as the result of a report of his committee one hundred and eleven years ago, the Connecticut Medical Society, in convention, went on record as favoring the establishment of an inebriate asylum.

This particular child of the Connecticut Medical Society—the Connecticut Retreat—and Eli Todd were destined to exert great influence far beyond the borders of the State. In 1832, when the State of Massachusetts wished to establish its first public institution, it sought the advice and services of Todd who sent in his stead one of ^{the} three younger doctors who for many years had come directly under his influence. Samuel Bayard Woodward, licensed by the Connecticut Medical Society in 1809, a convert and profound believer in the Retreat’s methods, was sent to Worcester to establish

the first psychiatric unit in the Massachusetts State Hospital System. This was the first offspring of the Connecticut Medical Society's Retreat.

The second offspring followed in 1836 when Doctor William H. Rockwell left its staff to establish the Brattleboro Retreat in Vermont, and a third—probably Todd's favorite pupil—was Thomas Goodrich Lee who came to the Retreat in 1830 upon his graduation from Yale. For two years Lee worked and labored at the institution but when his health failed he decided to travel and stopped for an inspection of the McLean Asylum, a branch of the Massachusetts General Hospital, then located at Charlestown. At that time little did Lee dream that two years later he would be invited to become the Superintendent of McLean and to there introduce the Retreat's methods.

The influence of Todd and the Connecticut Retreat continued to expand for when Dorothea Lynde Dix, the prim New England school teacher, embarked upon her ambitious career she took unto herself three psychiatric "godfathers" as her sponsors. Of these one was John S. Butler, Todd's successor at the Connecticut Retreat, another the same Sam Woodward whom he had placed at Worcester, and the third, Horace Mann.

Amariah Brigham was an intellectual with a scientific and analytical mind who came upon the scene as the stethoscope and scalpel made their appearances, the microscope and thermometer being in the offing; observations and statistical report were taking on new importance, pathological anatomy had become the rage, and phrenology was enjoying popular attention. Brigham was one of those interested in phrenology. He visited the great asylums in Paris—the Bicêtre and the Salpêtrière; he journeyed far and wide with keen appreciation of all scientific advances.

Upon his return from Europe he sought an opening in Hartford with the now famous Todd and in April, 1831, he became connected with the Retreat. In 1832 Brigham published a little volume entitled "The Influence of Mental Cultivation Upon the Health," wherein he showed the mental havoc wrought when children were forced beyond their capacity. The vast success of this publication undoubtedly encouraged him to new literary efforts a few years later when from the press came "The Influence of Religion on the Health and Physical Welfare of Mankind." It was about this time also that New England was in the throes of "Millerism." One William Miller, a farmer, became a revivalist and outdid in his conviction and ardor the great revivalists who followed him. He became convinced that Christ would return to earth in 1843, and in 1831 he felt called upon to impart this knowledge to sinful, suffering mankind. Huge tents were filled with his followers and immense crowds came to camp-meetings; some knelt on the hilltops at midnight; signs of Christ's coming appeared in the heavens; a meteoric shower was an omen. Thousand were converted, and the question was raised by Brigham as to whether many of the more hysterical had not had their reason unseated.

With these and other religious matters Brigham chose to deal in his own direct, forceful and inimitable way, with the result that he ran head on into public prejudice. From the pulpit ministers called him a skeptic and an

infidel; and prominent citizens belabored him in the press, but Brigham seemed only to enjoy the clamor and was heard to remark, "Well, the Reverend so-and-so damns my books but he certainly doesn't damn my advice when he is sick."

This sortie into the field of religion as related to insanity almost cost Brigham his opportunity to head the Retreat upon the retirement of Silas Fuller. But it was Brigham who at the Retreat made a beginning of the scientific study and evaluation of mental disease. He studied the pulse, made measurements and observations on the size and shape of the head, investigated the special senses, the body temperatures—both general and in various parts of the body—, studied the body secretions, and early related the diseases of the mind and body.

For the fourth time the Connecticut Retreat was to become the father of a state hospital system when Brigham himself transferred his measuring tape and thermometer, his weighing machine, his files of statistics and his own great intellectual curiosity and person to Utica, New York, where he became the first superintendent of that asylum from which stemmed New York's great state hospital system. It was not until his arrival at Utica that he put into practice his plan for establishing the journal now known as the *American Journal of Psychiatry*, the official organ of the American Psychiatric Association, the oldest existing society of medical specialists in this country. Of this society he was also a founder and an early president.

At the close of the Civil War in 1865 the seeds sown by the Connecticut Medical Society had grown to fruition, and there was general appreciation that an insane person was a sick person and the State had a broad responsibility for this group of unfortunates. For a second time a State-wide investigation revealed that more than half of all those afflicted were receiving no care in any institution, only one fourth of them could be accommodated at the Retreat, and another fourth were merely locked up in alms houses. In spite of State and National debts, the Connecticut Legislature, in 1867, began the construction of "a general hospital for the insane of the State of Connecticut" near Middletown, Connecticut.

Continuing its pioneer role in the care of mental patients, the State of Connecticut has since established, in 1903, the Norwich State Hospital; in 1917, the Mansfield Training School and Hospital—a consolidation of the somewhat older Colony for Epileptics and the Training School for the Feeble-Minded; and in 1940, the Southbury Training School and also the new and modern Fairfield State Hospital.

In the field of psychiatry not only has Connecticut led with its doctors and institutions, but its universities and laymen have made outstanding contributions. At the turn of the century there occurred an event which was to have marked influence on psychiatric thought throughout the world. A man named Clifford Beers wrote a book—he had been a patient at the Retreat, its name by that time changed to the Hartford Retreat, and a patient in the Connecticut State Hospital at Middletown. That book, "A Mind That Found Itself," following his mental illness from 1900 to 1903, was the seed from which the mental hygiene movement grew. The estab-

lishing of the Connecticut Society for Mental Hygiene, in 1908, was the first step in the nation-wide and world-wide mental hygiene movement and a year later, in 1909, that same patient was instrumental in organizing the National Committee for Mental Hygiene, of which Doctor Thomas W. Salmon became the first medical director.

Nor did this conclude Connecticut's contributions to psychiatry. In 1931, just a decade ago, the Institute of Human Relations was founded in New Haven as part of the Yale School of Medicine. This Institute is unique in that it combined for the first time all the sciences having to do with human behavior. Besides laboratories and clinical facilities of the departments of psychiatry and mental hygiene, there were also included laboratories of psychology and physiological psychology, laboratories of the clinic of child development and quarters of the anthropology division of research in the social sciences. This was not a separate school within the University, but had as its objective the stimulation of research in the field of human behavior among the faculties of the several schools. Roughly, these were to fall within three main fields: those concerned with the basic mechanism and processes of behavior and human relations, and with problems of method; second, those dealing with immediate problems of human welfare, such as employment, delinquency and mental disease—problems studied jointly by several sciences; and third, such studies as are concerned with specific problems in the fields of law, medicine, religion, education, economics and government.

* * * *

It is significant that a campaign against cruelty and superstition in the care of the mentally ill had its beginning with the Connecticut Medical Society and in a state where lived a woman whose most trenchant pen had helped to spell the dissolution of human slavery. Whether Harriet Beecher Stowe was influenced by Eli Todd in his hatred for mental cruelty and hatred for inhumanity, and for the cruelty that causes one group of human beings to treat another group as less than human, is not important; but it is important to remember that both movements grew from the hearts of people who had lived under the freedom of the Fundamental Orders and that the cause of human betterment has been fostered continually in Connecticut by permanent organizations and institutions which have flourished under its banner of human freedom and tolerance. It is also interesting to remember that here in Connecticut the guiding principles of humane care were early coupled with the scientific approach toward the handling of mental disease in the State of Connecticut. This modern conception is now one hundred and twenty five years old.

SCARLET FEVER IMMUNIZATION

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THE SUBJECT of preventive inoculation against scarlet fever has been one of moot speculation in the past. Because of its severe reactions, little was advised or attempted in this direction; many doctors preferring to treat the mild form of scarlet fever prevalent (at least in this vicinity for the past fifteen years) rather than subject patients to the severe and often distressing reactions following attempts at preventive inoculations. It has not been until within the past year or two that there has been a revised interest in this subject, owing probably to better preparation of the toxin and the fact that those inoculated did not contract the disease, plus less frequent and distressing reactions noted and charted. An excellent opportunity came to the writer in May, 1940, to inoculate sixty-eight New London County Home children against scarlet fever, this step being taken to combat what was fast becoming a small sized epidemic here in Norwich. It also occurred to us that we could learn much regarding the reactions so frequently noted in past attempts and to compare our results with past inoculations reported. So we decided to keep a careful watch on the reactions, chart them and later compiled results for publication. We first did a Dick test on seventy six children and adults and found sixty-eight positive reactions (the positive reaction being considered when the area of redness was .5 cm. or larger). The material used for immunization was scarlet fever streptococci toxin (Lederle) and the doses given here higher than those recommended, namely the dose recommended by the Committee on Immunization and Therapeutic Procedures of the American Academy of Pediatrics, i.e., 500—2,000—8,000—25,000—80,000 skin test doses given at weekly intervals; our procedure being to inject 650—2,500—10,000—30,000—100,000 skin test doses at weekly intervals. The reason these doses were given was because each vial contained the suggested dosage of a purified product. The ages of the children ranged from six to fifteen years and also included six adults (ages above twenty-one, the female age limit), on teachers and attendants at the County Home. The reactions were classified: first, mild; second, moderate; and

third severe; mild when only a local reaction occurred and very little constitutional symptoms; moderate when in addition to the localized redness we had slight or moderate fever, malaise, vomiting and occasional joint pains; severe when those injected had to go to bed because of fever, malaise, joint pains, sore throat or excessive vomiting.

First dose: 650 skin test units. We had 20 mild reactions, 40 moderate and 8 severe, and of the severe reactions 2 were adults. Second dose: 2,500 skin test units. We had 40 mild reactions, 18 moderate and 10 severe reactions. Third dose: 10,000 skin test units. We had 45 mild, 15 moderate and 8 severe reactions. Fourth dose: 30,000 skin test units. We had 50 mild reactions, 12 moderate and 6 severe reactions. Fifth dose: 100,000 skin test units. We had 55 mild, 11 moderate and only 2 severe reactions (I might add that none of the adults took the fifth dose, four being on vacation, and two refusing further experimentation).

Commenting on those who reacted severely, let me say that two of the children who reacted to all 5 injections came from very poor families, were badly nourished, subsequent to entering the County Home and their resistance was very poor. Two of the adults reacted to the four doses necessitating going to bed for two days. This is not at all surprising when one considers that the so-called childhood diseases occurring in adults are much more severe and complications more frequent. We had no later reactions whatsoever.

Comment on results: While it is true that the scarlet fever prevalent today is not a severe disease (at least within my memory of twenty years' practice), yet we do not know just when a virulent type may appear. It is the opinion of the writer that children and even adults can be inoculated against scarlet fever with a considerable margin of safety and that the procedure should be used much more frequently than previously followed. Most certainly, nurses, doctors, children in orphanages, county homes, preventoriums, sanatoriums and nursing homes should be given these inoculations. Possibly scarlet fever immunization cannot be put in the same class as diphtheria immunization but we do feel that it definitely has its place in preventive medicine. The

(Concluded on page 740)

OBSERVATIONS UPON THE SIMPLER TECHNIQUE IN SCARLET FEVER IMMUNIZATION

A Preliminary Report

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THE GENERAL public is constantly becoming more convinced that multiple immunizations are necessary to combat the various communicable diseases. The reason for their reaction is obvious in that the required measures are certain and not too discomfoting for the most part to the recipients. I feel it can be definitely stated that scarlet fever itself in most cases is distinctly worse than the usual prophylactic measures necessitated. The exceptions of course do become apparent occasionally. However, five injections — (650 — 2500 — 10,000 — 30,000 and 120,000 skin test doses, respectively) administered prophylactically against scarlet fever together with two Dick tests, a minimal total (more injections are necessary if the Dick test remains positive) of seven in all, most frequently brings forth onerous protests from a mother. Such complaints of course are to be expected. Consequently, any shorter procedure that is of assured worth may not only be welcomed by the fond parent, but there even might be a manifestation of enthusiasm for its successful completion. However, it is not my intent to conceal any unpleasant sequelae associated with its administration.

There have been various papers which have reported work done with intradermal injections of toxin. All investigators agreed that systemic reactions were less severe and less common after such injections. It is also true that smaller doses were used than by the subcutaneous route. For instance, Robinson¹ used 50—200—800—2500 and 7200 skin test doses respectively. Kern² and associates employed 50 and then graduated usually up to 800 skin test doses, the maximum dose being repeated until the subject became Dick negative. The immunity conferred was evanescent in 60% of the cases.

On the other hand, Taylor³ has demonstrated that while a typical intracutaneous bleb represents a separation of the epidermis only, it is impossible

from a practical standpoint to accomplish this owing to the thinness of the skin. He demonstrated the actual happenings in the correctly made intracutaneous injections by using India ink for the inoculi. Subsequent sections of the blebs revealed that none of the ink was in the epidermal layers but in the corium and even in the subcutaneous fat. The epidermis varies in thickness from 0.07 to 0.12 mm. on most parts of the body. From my own experiences I have frequently found that when the intradermal wheal became too large in size for a particular individual, there simply had to be a rupture of the dermal layers releasing the fluid either into the subcutaneous tissue or through the surface of the skin (the latter was not usually immediate but occurred within the first eighteen hours). Consequently, the tensile strength of the epidermal layers and the possible potential size of the wheal before rupture occurs must vary with the individual.

It would then follow that an actual intradermal injection is close to being impossible unless the amount injected is quite small. With a larger quantity its intradermal determination will depend upon the dermal elasticity present. But by logical inference most of our injections must follow the combined intracutaneous and subcutaneous tissue routes and infrequently the major portion of the injection is lost by the external rupture through the corneum.

For this reason could it not be argued that the skin test doses of toxin as was originally advocated by Doctors George F. and Gladys H. Dick⁴ be approached as the standard, realizing that a certain amount will reach the subcutaneous layers? Upon this premise large doses of scarlatinal toxin were administered in the series of cases herein reported.

The following routine has been observed in private practice upon those patients having no conscientious objections to the scarlet fever immunizations.

When the usual Schick test was administered to infants at about the age of 15 months, a Dick test was done sequentially. If the Dick test was found to be positive, the parents were then familiarized with the fact that scarlet fever immunization was at

their voluntary disposal and that the injections could be started at eighteen months of age.

The following data has been compiled for the purpose of reducing the need of the usual five immunizing injections. However, in attempting to pioneer any field of immunization wherein the major medical sentiment of the locality does not favor it, to prove its worth often becomes a mammoth task.

During a period of over three years I have had 69 cases* requesting its administration. In ages,,

25 at 18 months	3 at 8 years
17 at 2 years	1 at 9 years
6 at 3 years	2 at 10 years
2 at 4 years	1 at 11 years
1 at 5 years	2 at 12 years
3 at 6 years	1 at 13 years
5 at 7 years	

The older children receiving the toxin represented the remaining Dick positive ones in the family whom the parents desired to have covered in the immunization process. These older children were usually done at the same time as the infants.

The following information has been derived from this series of cases: Total number of individuals immunized was 69. Thirty (30) or 43.4% developed nausea (older children) or vomiting or both, and most often a reaction followed each injection, especially when it occurred after the first injection. This was definitely reduced by having the recipient receive no noon day meal also by making early afternoon appointments and finally by suggesting that a light evening meal be partaken of, (toast or crackers and sweetened tea without milk) if vomiting would not prohibit the ingestion of all food.

Fifteen (15) or 21.7% developed a slight degree of generalized rash after the initial dose of toxin. Most of these had an erythema involving the trunk. The rash subsided within twenty four hours—desquamation was not observed in any of these. A varying degree of local reaction about the site of injection was universal and was frequently followed by desquamation.

Fever usually slight, persisted up to 49 hours in ten (10) or 16.6%.

Headache, anorexia and fussiness persisted up to 3 days in twenty one (21) or 30.4% after most of

the injections in the series.

Transient albuminuria was observed in 3 or 4.4% after the first dose.

It was necessary to give a fourth dose of the toxin to twelve (12) or 17.4% the same day that the positive Dick test was read two weeks after the third dose of the toxin. Eight (8) of the twelve were in the 18 and 24 months age group, one was in the third year group, two in the seven year group and one in the ten year group. It is quite possible that most of these were given a fourth dose of toxin needlessly, as none received a control test with the actual Dick test. If the control test and the Dick test readings are equivalent in redness, the actual test would be evaluated as negative for it would represent sensitivity to the toxin and peptone proteins. Doctors S. Fisher and D. W. Van Gelder⁵ reported equivalent readings with Dick and control materials. This group will be further reduced in the future because of the greater toxin potency if intradermal immunizations depend truly upon the number of skin test doses administered. None of this group could be prevailed upon to return for a third Dick test, so complete results are lacking.

As far as has been ascertainable, none of those who have received the toxin have developed scarlet fever. The actual degree of immunity will vary with the individual, as will its duration.

Even for a procedure which gives reactions which are somewhat more severe than those of pertussis immunizations, it does seem fitting that additional stress should be placed upon its more generalized usage, but it must be borne in mind that it is the method of choice only in those individuals who cannot swallow tablets. Doctors George F. and Gladys H. Dick⁶ have recently described a method of oral immunization against scarlet fever with enteric-coated tablets of concentrated scarlet fever toxin in graduate doses reaching a maximum dosage of 10 million skin test doses of toxin given in one day. They summarize the advantage of this route of approach: it causes fewer reactions, particularly in young children, that it requires less time, that the dosage is more readily adjusted according to the reaction the individual may manifest and that it is preferable to hypodermic injections in persons previously sensitized to proteins contained in peptone, a condition not infrequently found in persons who have been immunized with alum precipitated diphtheria or tetanus toxoid.

It should be mentioned that previous to the use of

*Since writing the above, fourteen additional children were immunized. Thirteen developed some of the sequelae mentioned after one, two or three of the injections. One was spared entirely. Thirteen were also Dick negative after the usual two weeks had lapsed following the third injection.

THE GENERAL SCHEME OF TOXIN ADMINISTRATION

DOSE* AMT & VIAL USED	SUPRARENIN I-1000**	ROUTE	TIGHT FITTING SYRINGE	NO. SKIN PUNCTURES***	TOTAL FLUID GIVEN	COMMENTS ON PROCEDURE
1. 3,000 S.T.D. 0.1 cc. Vial 4	0.1 cc.	INTRA- DERMAL	TUBERCULIN	1	0.2 cc.	The outer surface of the arm was the site of election. It is essential for the subject to receive this injection wholly intradermally in order to permit slower absorption and less general reaction from this large initial dose. Also, not to emphasize any less the immediate antitoxin response, which is necessary from this dose in making ready for the larger second dose.
2.* 12,000 S.T.D. 0.4 cc. Vial 4	0.1 cc.	INTRA- DERMAL	TUBERCULIN	1 or 2	0.6 cc.	Proceed cautiously with the wheal creation. If a subcutaneous wheal appears, this will tend to act as a splint when the needle is withdrawn to be reinserted between the layers of the skin overlying this undesirable wheal. Very little of the toxin will have been lost subcutaneously in the procedure.
3.* 108,000 S.T.D. 0.9 cc. Vial 5	0.2 cc.	INTRA- DERMAL Entire cc. if possible	USUAL 1½ to 2 cc. Luer	2 or more	1.2 cc.	Progress as before or attempt to extend the needle point into the advancing wheal. If this is not possible, reintroduce the needle point into new sites. Recently the skin test doses were increased by the committee for greater effectiveness. The statistics noted herein were based upon the old toxin. For instance, Dose No. 5 used for the 3rd injection in the series represented 2cc. of toxin equivalent to 80,000, possibly up to 100,000 S.T.D. One cc. of this was injected intradermally and the remaining one subcutaneously. The present one (1) cc. dose will not only simplify its administration but enhance its value because of its greater potency.

*Administered at weekly intervals. If the Dick test was positive two weeks after the third injection, the third dose was again repeated as has been recommended by the Doctors Dick. Regarding the Dick test, 0.1 cc. Dick test toxin is used, usually on the inner surface of the forearm intradermally. Positive reactions show all gradations from small areas that are off color to large intensely reddened areas. Spinek⁷ stated that identical reactions were observed whether the test be given intradermally or subcutaneously. If there was a too marked reaction after the first dose of toxin, the second and third doses were reduced up to 25%.

**Tuft² mentioned the use of suprarenin to further delay the absorption of toxin and thereby to decrease its reaction.

***A No. 26 gauge, ½ inch length needle with a sharp point is satisfactory.

the intradermal toxin, the five subcutaneous injections as are recommended by the Dick were used by me. The reactions were about equivalent in both groups.

The extent of success in any immunological measures depends entirely upon the physicians concerned. Pertaining to the scarlet fever immunization procedure to date, I do not feel that the majority have been quite fair to its unquestionable potential worth in combatting the toxic phase of the disease. The introduction of sulfanilamide and neoprontosil as specific drugs has not obliterated the necessity for prophylactic measures for the reason that complications still occur and the long isolation period could not be considered as pleasant. Of course we all realize that some individuals develop a gradual immunity to scarlet fever through the mechanism of repeated

exposures to the scarlatinal beta hemolyticus, but how can one determine who those persons are when Dick testing is not done to determine their immunological state?

I apologize for the small group of cases reported. Doctor Gladys H. Dick was generous enough to supply me with enough material for a much larger group, but unfortunately local opposition prevented the innovation of the program.

The fact that there is much divergence in the amounts of intradermal toxin administered and the intervals of injection suggested by different investigators should encourage further work to be done toward exacting these phases.

SUMMARY

Sixty nine (69) cases were immunized with scarlatinal toxin. Fifty seven (57) of these received three

(3) intradermal injections and the remaining twelve received four (4) such injections, some of the latter probably needlessly for the reason that a control Dick test was not done (the Dick test done to determine immunity after the toxin injections should be controlled with control material). The reactions on an average for the group were distressing but not too severe. None of the group to date has been known to develop scarlet fever. Standardization of the doses and time intervals of injection of intradermal toxin are necessary. Oral immunization as described by Doctors George F. and Gladys H. Dick should prove a great boom in prophylaxis in all those able to swallow tablets. Future work should be carried out so that eventually the usage of scarlet fever prophylaxis will become universal.

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- I am indebted to E. R. Squibb & Sons and Doctor Gladys H. Dick for their supply of free scarlatinal toxin.

Fishbein Goes British

Doctor Morris Fishbein, editor of the *Journal of the American Medical Association* and one of the

foremost medical men of the United States, has joined the British American Ambulance Corps' Chicago Committee, according to William V. C. Ruxton, President of the B. A. A. C.

The British American Ambulance Corps which maintains national headquarters at 420 Lexington Avenue, New York City, is the largest medical relief organization now sending equipment and supplies to Britain, China and the Near East. The corps recently shipped its 600th ambulance abroad. These units ranged in cost from \$1,350 for the light panel type, widely used in bombed industrial areas to \$2,000 for the super capacity equatorial type now urgently needed in the Western desert of Africa.

The British American Ambulance Corps also is supplying the recently developed mobile x-ray unit which operates under its own power in the field. The new motorcycle ambulance, fastest machine now engaged in saving lives in war, also is in production.

The ambulance can travel at 90 miles per hour and can go through terrain inaccessible to larger units.

SCARLET FEVER IMMUNIZATION

(Continued from page 736)

immunization should not be started before twelve months of age and preferably after eighteen months of age.

In closing, my sincere thanks is rendered to the Board of County Commissioners of New London County for their foresight in initiating these inoculations and providing the money necessary to carry on this work; to Mr. and Mrs. Hubert Dart, Superintendent and Matron of the New London County Home in Norwich for their real enthusiasm and coöperation in this work; to the Norwich Public Health Nursing Association in providing nurses to help with these inoculations. I sincerely feel that all the above contributed materially in bringing to the public gaze a procedure which will prevent disease and may be an incentive to others to inoculate more frequently against scarlet fever.

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SOME CLINICAL OVERSIGHTS OF SIGNIFICANCE

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The Author. M.D. *Yale University School of Medicine, 1924. Assistant attending physician New Haven Hospital. Clinical Instructor in Medicine, Yale University School of Medicine*

THE FOLLOWING remarks are not in the least an attempt at communicating anything original. They are probably a matter of common knowledge to most of us. Yet, they are motivated by actual observations in the private practice of medicine which are not rare although the educational standards of our medical schools and the post-graduate training at most of our hospitals might seem to preclude such experiences entirely. The venture of this brief presentation is, therefore, dared with the understanding and with the hope that it will convey an important message to not many among us.

ACUTE TONSILLITIS

One of the most common ailments faced by the greatest number of physicians is acute tonsillitis. In itself hardly meriting any significance, it is, nevertheless, a focus of infection and it contributes a certain number of prospective cases of acute nephritis. These cases of metastatic renal infection often remain mild and unrecognized for some time, and they may not receive any attention until the appearance long afterwards of frank signs and symptoms of chronic nephritis. To be sure, the constitutional predisposition to such consequences of acute tonsillitis is fortunately limited to not many individuals, and most patients recover uneventfully from upper respiratory infections. Yet, Bright's disease is a grave enough disease to deserve routine preventive protection of all potential cases regardless of how few they may be. It is, therefore, necessary to follow up every patient for several weeks after recovery from acute tonsillitis by repeated urinalyses, including microscopic examination of the centrifuged urinary sediment, and to temporarily confine to absolute rest in bed all those who happen to show evidence of metastatic renal infection. Such practice, however, is quite uncommon despite the emphasis with which it was urged by some eminent clinicians.

ORTHOSTATIC ALBUMINURIA

In connection with the general subject of urinalysis, it is probably safe to say that no modern physician would hurriedly diagnose diabetes melli-

tus because of his finding of glycosuria alone without any further study of the patient. On the other hand, a finding of albuminuria occasionally "suffices" to establish an ill founded verdict of kidney disease in persons who exhibit no subjective or objective evidence other than albumen in the urine. Such individuals should be requested to submit for examination diurnal and nocturnal specimens of urine on several occasions. They will then often be identified with ease as cases of harmless orthostatic albuminuria.

With regard to the examination of urine for its possible glucose content, one is tempted to smile at the insistence with which many insurance companies demand mailing of the specimens for examination to their main offices. Many an urinary specimen completing its twenty-four hours journey in the middle of a hot summer fails to show a reduction not because it was free from glucose, but because fermentation of the glucose disposed of its traces.

THE PROTEIN INTAKE

A note of regret cannot be suppressed in connection with the antiquated, but still prevalent undue restriction of the protein intake of patients who do have albuminuria of real kidney disease without any indication for such restriction, and without clinical or laboratory evidence of nitrogen retention. It is very unfortunate that there are still many instances of unnecessary or even harmful prohibitions of the patient's protein intake just as soon as albumen appears in the urine. This is carried to an unusually deleterious extent in cases of nephrosis which notoriously presents no threat of azotemia as a rule but which constantly manifests a heavy albuminuria with a fairly normal urinary specific gravity, marked edema, and little if any elevation of arterial tension. Their plasma protein level is depressed and they are precisely the patients who should be given the urgent advice of a liberal protein intake.

This consideration brings one to the general problem of plasma protein depletion which occasionally arises with or without kidney disease, produces intractable edema, and is often not thought of by the attending practitioner. Many a time a simple investigation of the patient's dietary habits, and each time a laboratory determination of the plasma protein level would soon enough throw light on the

obstinacy of the edema and on the necessity of increasing the patient's protein intake.

USE OF MORPHINE

At the risk of what might appear to be superfluous repetition one is, nevertheless, impressed with the still existing need of stressing the failure of prompt hypodermic use of morphine when it is most urgently needed, namely, in coronary thrombosis and in pulmonary edema. Indeed, one sees here and there a prolific polygragmasia displayed at the bedside in either instance consisting of parenteral injections of all sorts of stimulants instead of the immediate use of morphine. Yet, one cannot help stating without the slightest hesitation that morphine is of inestimable value not only at the time of the acute onset of coronary thrombosis but that it may also be of the greatest help to the patient in the course of weeks following myocardial infarction. An example of this was seen recently in a clergyman who seemed to be recovering uneventfully from coronary thrombosis until one day he received an unpleasant, pressing letter from his bank. Within the next half an hour his excitement was followed by an episode of tachycardia, feeble pulse at the wrist, profuse perspiration, cold, clammy extremities, and an attack of pulmonary edema. Prior to the writer's arrival at this patient's bedside in the hospital, the interne had employed oxygen inhalations, aminophyllin intravenously, and some other measures without demonstrable improvement of the patient. Morphine, however, had not yet been used. When it was finally resorted to, it was followed by gradual cessation of the distressing picture. About ten days later this same patient was told unnecessarily the disappointing news of another member of his profession having just been promoted ahead of him, and again a picture such as just described ensued immediately after the receipt of the bad news. This time morphine was injected at once with very gratifying effect. Such and many other similar experiences would seem to justify calling attention to the important need of using morphine in particular, and effective sedatives in general, most liberally at least in those patients who are afflicted with serious cardio-vascular diseases and who harbor within themselves the dangerous element of too much emotional imbalance.

NITROGLYCERIN HARMFUL

Coronary thrombosis frequently prompts the attending physician to administer nitroglycerin.

This is sometimes due to failure of drawing a diagnostic distinction between coronary thrombosis and an anginal seizure, especially if the patient is known to have been suffering from angina pectoris relieved by nitroglycerin. At other times, however, the diagnosis of coronary thrombosis is made correctly, and nitroglycerin is employed deliberately. It would be safe to say that general consensus of authoritative opinion would favor eliminating nitroglycerin from the therapeutic armamentarium of coronary thrombosis because it may, instead of being helpful, do a great deal of harm by still further aggravating a drastic fall of the blood pressure already encountered in many instances of coronary thrombosis.

VALUE OF STROPHANTHIN

In pulmonary edema subsequent to left ventricular failure in the course of chronic heart disease, the use of strophanthin also demands brief comment. On some occasions, the drug has been injected with disastrous results when it should not have been used because of considerable digitalis therapy preceding the episode of pulmonary edema. At other times, a possibly life saving parenteral injection of strophanthin has not been given although there was no contra indication to its use.

DIGITALIS THERAPY

The clinical use of digitalis might be assumed to be so well and so universally understood as to require by now no further discussion. Actually, however, this sense of security is marred once in a while by an unpleasant disappointment. Attention will be called here to only one pertinent problem, namely, that of digitalis intoxication.

When the usual symptoms of digitalis poisoning, nausea and vomiting, are mild and overlooked, or when the patient, for some reason or other, is not seen by the physician at all for a period of several days after the initial stage of digitalis overdosage, a picture may then develop which is bound to be misleading. Bradycardia and evidence of ectopic beats in the form of coupled rhythm or otherwise may no longer be present, and, in the absence of that warning signal, the impression may be gained of a regular rhythm with a very rapid rate. Indeed, the rate may be faster than it was prior to the commencement of digitalis medication a week or so previously. In the belief that the heart rate has *not yet* been reduced by the drug, more digitalis is given, and, before long, injury added to insult produces a situation

pregnant with the gravest consequences.

An interesting case of moderate digitalis intoxication will be summarized briefly, as follows: A middle aged, rather ignorant woman afflicted with old healed mitral stenosis and aortic insufficiency of rheumatic etiology was seen approximately one year ago. A few weeks previously she had decided, after many years of total lack of medical supervision, to consult a physician. She received a prescription for digitalis leaf pills, each 0.10 gram, together with specific instructions as to their correct use. Within about ten days she developed nausea, vomiting, and a great deal of abdominal distress. The patient then called two other doctors, of whom the last was a young surgeon. X-ray studies were made to rule out gall bladder disease, and the diagnosis of ectopic pregnancy was arrived at. Resisting the subsequent advice of entering the hospital for an immediate operation, the patient decided to consult still another physician. She was then found by this writer in a state of severe gastrointestinal distress, and her heart displayed a persistent coupled rhythm. In addition to that, upon questioning the patient, it was easily ascertained that she had completely ignored the first physician's instructions as to the use of her digitalis pills, and had been taking many more than she was told to. After withdrawal of the drug the patient gradually recovered from digitalis poisoning, and showed no sign of pregnancy during the following months.

The last mentioned clinical oversight also illustrates in general the danger of hasty and onesided opinion hampered by its confinement within a too narrow field and void of the benefits of a broad clinical scope. In this sense, the above described case is as instructive as the one of another patient who received more than one pair of eye-glasses without improvement of his vision while suffering unknowingly from moderately advanced combined sclerosis. He was finally referred by a competent ophthalmologist for a complete physical examination. Motor and sensory neurological changes with partial involvement of the optic nerves were revealed, and prompt treatment including the use of liver extract brought about general as well as visual progressive improvement.

A Warning Against Driving When Taking Sulfanilamide

"Many therapeutically effective drugs influence the physiologic mechanisms, psychomotor [muscular coördination] reactions or judgment of persons who take them," *The Journal of the American Medical Association* for May 17 points out in a warning on the dangers of impaired judgment resulting from the taking of sulfanilamide and its derivatives. "When given to patients at rest in bed such drugs have been established as beneficial to the patient and of course harmless to other persons.

"Under some circumstances, however, drugs may have effects potentially dangerous to both patient and community. Not long ago a locomotive engineer who was taking sulfanilamide for an infection of the bladder was involved in an accident in which considerable property damage was done and a number of people were injured. He described the event as follows:

"Approaching the station where the accident occurred, a feeling of lassitude seems to have crept over me unawares and to the extent that I do not have much recollection of what went on for the last two or three miles. I was sitting on my seat, looking out and feeling that I was on the alert. . . . Actually I was not on the job with all my faculties. I passed landmarks customarily used to locate position without seeing them, even to the station board; and it was only when the hazard became imminent that I was aroused out of it and became efficient.

"Already physicians have ruled that airplane pilots must not fly until four days have elapsed after they have received any of the sulfonamide group. Patients engaged in mechanical work of any kind should not take sulfanilamide except when relieved from their responsibilities. Physicians thus have a definite obligation when prescribing sulfanilamide.

"Patients should be cautioned preferably to stay at home and at rest while taking the drug and not to drive an automobile, make any important decision or sign any papers while the drug is being administered. Such recommendations seem especially advisable in view of the insidiously developing reactions of sulfanilamide when compared with such drugs as the bromides and the barbiturates."

NINETEENTH JOINT MEETING OF THE ASSOCIATION OF CONNECTICUT TUMOR CLINICS

Middlesex Hospital, December 12, 1940

CARL C. HARVEY, M.D., *Chairman*

CARCINOMA OF UTERUS, MIDDLESEX HOSPITAL

G. M. CRAIG, M.D.

In the years 1934-1939 we have had available for statistical study as private and ward cases at the Middlesex Hospital twenty carcinomata of the uterus. Most of these have been treated at the hospital, but since we lack facilities for deep x-ray therapy some of them have had follow up treatment elsewhere. In this analysis we have a report from the patients' local physicians or from our follow up clinic as to the outcome or present status of the cases.

Our youngest patient was 41 years of age and the oldest was 81 years with an age distribution as follows:—

- 6 or 30%—Fifth Decade
- 5 or 25%—Sixth Decade
- 3 or 15%—Seventh Decade
- 5 or 25%—Eighth Decade
- 1 or 5%—Ninth Decade

There was considerable variation in the duration of symptoms before consulting a physician. Far too many, nine or 45%, waited from six months to two years and there was a range from two days to two years. In evaluating the influence of fear or ignorance as reasons for delay in first reporting to a physician we find that the social level of the patients made but little difference. Some of the more intelligent waited far too long and some of obviously poor mentality were no more dilatory than their better equipped sisters. Inertia, pure and simple, seemed to be the only cause for a serious procrastination in several of the cases. There were only three out of the twenty cases who presented themselves to their physicians within a week of the first symptom and, as it happens, none of those lived more than a year after discharge from the hospital.

In a critical analysis of the doctor's promptness in initiating treatment we find that here, too, there seems to be room for education. Two cases were seen two years prior to hospitalization; one more, one year; and five cases were postponed about six months before coming in for treatment. This situation has evidently improved within the last few years; most

of these delays were in the earlier years of the reported five year span.

Sixteen of our cases presented either spotting, a characteristic bloody discharge, or a hemorrhage as the first symptom. One showed a discharge plus a vaginal mass, one presented a discharge accompanied by weakness, and a third entered the hospital for a supposed osteomyelitis of the metatarsals which upon investigation proved to be a broken down metastasis from an unsuspected uterine cancer.

In only one case was there noted a family history of cancer. This woman's father died of a prostatic cancer.

Twelve of our cases were diagnosed by biopsy, four were discovered on examination of hysterectomy specimens. Four cases had only a clinical diagnosis, one of these because treatment was refused, one because she entered the hospital with a rapidly terminating carcinomatosis, and two were too old to have anything done for them. All the patients on whom clinical diagnoses were made are dead, as would be expected, because of the advanced stage of the disease.

The Pathology of these cases is as follows:—

Fundus: Adenocarcinoma—12

GRADE	STAGE
I—3	I—4
II—5	II—5
III—2	III—2
No tissue diagnosis—2 (one refused, one too far advanced)	Not Known—1

Cervix: Squamous Cell—8

GRADE	STAGE
I—0	I—1
II—1	II—1
III—5	III—5
No tissue diagnosis—2 (one refused, one no biopsy)	Not Known—1

Our treatment was as follows:—

Fundus

- Radiation only—2
- Operation only—4
- Dilatation and Curettage and Radium—2

No treatment—4 (one inertia after discharge, one transfer to Connecticut State Hospital, one refused, one carcinomatosis)

Cervix

Radium only—4

Radium and deep x-ray—1

Surgery—1

Refused Treatment—1

No Treatment—Transferred to another Hospital—1

Results:

This heading is the hardest one to evaluate accurately, for the type, grade, and stage are not the only criteria, and to this must be added the possibility of death from other causes.

In this entire series two have died from causes unrelated to their pelvic condition, one of cerebral hemorrhage, one of coronary thrombosis. One more died one year after discharge with no evidence of recurrence.

Of the twelve cases of carcinoma of the fundus three died within six months, two had received radium only, one had had a hysterectomy. Four cases died under one year, two with no treatment because of their advanced pathology, one had a hysterectomy, and one had only radium. One who had radium treatment alone died after two years of a cerebral hemorrhage; one who had radium and x-ray died after two years of a coronary; and one who was treated with x-ray and radium is alive at the end of two and a half years, but has a frozen pelvis. One who had a hysterectomy is alive and well after three and a half years. One who had radium followed by hysterectomy in six months, is alive and well at the end of five years. This gives a per cent of 58.5 who died of cancer, 16.5% who died from other causes and 25% living and, since one of these has a frozen pelvis, 16.5% living and well. These are based on the total number of cases. A corrected percentage figured on patients treated shows 37.5% living with 25% living and well.

The cervical cases show four who died between one and six months, all of them having had radium. One refused any treatment and lived two years to die of a cerebral accident. One died of other causes; in another institution, one year after admission to our hospital; the discharge note on the patient's chart states that she died of terminal bronchopneumonia and in addition adds that she had a pelvic carcinoma. Evidently this was untreated. Two cases

are living after one year, but one has a frozen pelvis. This one had radium plus deep x-ray therapy. One is apparently free of disease. She had radium only. This gives a percent of 50 who died from cancer, 25 dead from other causes and 25% living and since one of these has metastasis 12.5% living and well. Since only six of these were treated this gives a corrected per cent of 33⅓% living and 16.5% living and well.

This series is a very small one, and from the standpoint of treatment little can be learned in regard to the best way to attack the problem. The most startling fact brought out by the analysis of our cases is the surprising amount of inertia and/or ignorance displayed by women who have uterine cancer. In some few cases more alertness on the part of the family physician would have been of possible benefit to these women, but the outstanding feature of the histories is the unduly long time during which women will complacently accept the presence of abnormal or unusual vaginal symptoms. We hear that cancer talk is being over done, that people are getting cancer phobias. Whereas this may be the case, it would seem better to have several women worry and finally consult their physicians for reassurance and treatment rather than to allow one woman to go unacquainted with the need for an examination when her ignorance may be the cause of her ultimate doom. Physicians are probably becoming more cancer conscious; that is as it should be, but the education of the laity to the point where it is willing to ask for advice before it is too late for the advice to be effective is something for which we, as physicians, should constantly strive.

CARCINOMA OF THE BOWEL

LOUIS O. LA BELLA, M.D.

We have had, in the past five years, 32 cases of carcinoma of the intestine. One of these cases was in the duodenum at the anapulla of vater. This case was treated by preliminary common duct drainage because the gall bladder could not be made sufficiently mobilized for the more accepted procedure of cholecysto-jejunostomy, which would later have been followed by resection of the duodenum, etc. This case died before any further surgery could be carried out. The other 31 cases were all in the large bowel and were situated as follows:

Carcinoma of the cecum—2

Carcinoma of ascending colon—2

Carcinoma of descending colon—2

Carcinoma of transverse colon—3

Carcinoma of sigmoid—5

Carcinoma of recto-sigmoid—7

Carcinoma of the rectum—10

Age: There was quite a range in age limit in these cases, the youngest being 36, the oldest 84. A more detailed analysis showed 2 cases in the 4th decade; 3 in the 5th decade; 9 in the 6th decade; 12 in the 7th decade; 3 in the 8th decade; and 3 in the 9th decade.

Sex: Fifteen of these cases were males, seventeen were females. This makes about an even sex distribution.

Symptoms:

The duration of symptoms in these cases is extremely difficult to determine with any degree of accuracy. One patient stated that he had a mass protruding from his rectum on and off for 15 years. This had been accompanied by bleeding for a similar length of time. On the other hand a large number of cases presented themselves with symptoms and signs of intestinal obstruction of very short duration. So that we have a time element from the appearance of symptoms to the instituting of treatment ranging from 15 years to one day. How much reliance one can place in most instances on the statements made by patient or relatives is extremely problematical, in view of the pathological findings at operation in most of these cases. The time elapsing from the patient's first visit to the physician to admission into the hospital ranges, in this series, from one hour in a case of massive hemorrhage from the stomach associated with diarrhea to 2 years. In the latter case the physician in charge actually had the patient in a hospital on one occasion but no pathology could be proved at the time. The former case was one of carcinoma of the transverse colon which had ulcerated through into the fundus of the stomach, producing marked diarrhea from the gastrocolic fistula. The massive hematemesis resulted from erosion of a large vessel which was discovered at operation.

Presenting Symptoms:

The symptomatology in these cases was extremely varied. It certainly was not the text book type that one so often would like to find. Intermittent constipation, cramp like pains in the abdomen of varying intensity and duration, swelling of the abdomen, a mass that was actually noted by the patient before she consulted her physician, bloody stools, weakness, swelling of the ankles, loss of weight. These symptoms were found in various combinations and could

easily be interpreted by operative or x-ray findings.

Family History:

One case gave a history of carcinoma, site unknown, in the mother and one brother. One man gave a history of carcinoma of uterus in the mother. All other cases gave a negative family history.

Diagnosis:

The diagnosis in 16 cases was suspected clinically and confirmed by x-ray findings. One case of carcinoma of transverse colon gave negative x-ray findings. Ten cases had no x-rays taken at all, but the combination of symptoms, with bloody stools and proctoscopic findings were sufficient to warrant operative interference. Two of the cases had definite palpable rectal masses, and one had such constriction of the rectum that the finger could only be inserted with much difficulty. In all cases, except those who refused operation, the clinical and x-ray diagnosis was confirmed by operative findings; and small wonder when one considers that most of these cases were markedly advanced cases.

Pathology:

We have already given the details of the location, of these tumors. The type of growth was determined by the pathologists' examination in all but 13 cases. In the latter group it was impossible to take a specimen, either because of the location of the lesion, its advanced character, or because the patient was in such poor shape that it was deemed inadvisable to do any extensive surgery. Three cases refused treatment. When the specimen was obtained either by resection or biopsy, the pathological report showed adenocarcinoma graded as follows: Grade I—3 cases; Grade III—1 case; Grade IV—1 case; Not graded—12 cases; and epidermoid Carcinoma, Grade IV—1 case, and Grade III—1 case.

All but 6 cases showed metastases spread either in the liver and periaortic glands or in the mesenteric glands, that is, 81% of all cases showed metastases.

Treatment:

Three cases were not operated upon, one because he was in such poor shape that operation was deemed contraindicated, the other two because they refused treatment. These three, may we mention in passing, are all dead. The procedures followed in those who received operative treatment were as follows:

(1) Resection either in one or two stages depending upon the location of the tumor and the condition of the patient was possible in only nine cases.

(2) Colostomy, as a palliative measure only, was done in 16 cases.

(3) Exploration and not even colostomy done in 2 cases.

(4) Died on operating table during process of resection, 1 case.

(5) Drainage of common bile duct, 1 case.

Results:

Died in the hospital—18 cases or approximately 57%. The length of stay in the hospital ranged from one to 67 days, with an average hospital stay of approximately 18 days. Those who left the hospital alive were 14 or approximately 43%. Of these we have five living from 1½ to 5½ years. This makes 36% of those who left the hospital alive still living and 16% of all cases living from 1½ to 5½ years; of the 9 cases resected, 5 living—which makes a corrected percentage of 55%. The remainder died from one month to one year from the time of discharge from the hospital.

Conclusion:

One might well remark upon the relatively few cases alive in this series. There are certain definite factors, however, which must be taken into consideration in the proper estimate of such a statistical study. First of all, the ages of these patients added materially to the poor outcome. Looking back at our age grouping it will be noted that only two cases were within the fourth decade. These two patients both died, one because of the gastrocolic fistula with hemorrhage and shock; the other because at operation his carcinoma at the rectosigmoid was found to have already spread widely and involved the liver. Of the three cases in the fifth decade, one is alive at the end of 5½ years, one is alive at 4½ years, and the third died in the hospital. She had carcinoma of the rectum and expired after the first stage of a contemplated abdominal perineal resection had been performed. Of the 9 cases in the 6th decade, none of them lived beyond one year after admission into the hospital. It would be too tedious to enter into a detailed account of the cause of death in all these cases, but hypertension, nephritis, poor cardiac condition, inoperable carcinoma, refusal of treatment, generalized peritonitis from perforation were amongst the causes of death noted. We had, you will recall, twelve cases in the 7th decade. Of these one is still living at the end of four years, one at 2½ years and one at 1½ years. In this group we have, it will be noted, the largest number of cases in the series.

We also have the largest number of these living. The three cases within the 8th and the 3 cases in the 9th decade are all dead. One wonders how long a patient 84 or 81 or 80 can live with myocarditis and anasarca and intestinal obstruction. Yet in one of these cases, the above was the admission diagnosis. One may also wonder how a patient in the seventies can long live with carcinoma of the sigmoid and carcinomatosis. So that, in the final analysis, the mortality rate cannot be attributed wholly to the carcinoma and its natural complications, but to the added pathology and poor operative reserve which accompanies old age.

One more striking thing may be noted from this series, that is, the relatively short time that elapsed between the time the patient noted the symptoms and the time treatment was instituted in so many of our cases. The explanation for this, in view of the markedly advanced pathology found at operation, may be found in the insidiousness of the onset of cancer of the bowel, the fact that the colon is so frequently the site of other pathologic processes which resemble carcinoma in their clinical manifestations and leads the patient to diagnose his own ailment as anything but the true condition. From the histories in the series the longest time that elapsed from the day the patient consulted her physician to the institution of treatment was two years. This, peculiarly enough, is the patient who is still living at the end of 5½ years. Next longest time was 8 months; one patient was treated for hemorrhoids for 3 months. When this patient entered the hospital he had a well advanced anemia as well as wide spread metastasis; in one case, the patient waited two months by his own choice; the remainder of the cases were admitted within a period ranging from one to 27 days. That does not speak so badly, I believe, for the medical group in this and surrounding communities served by this Hospital.

And now, to get away from statistics we would like to present a case which lived for 18 years after the primary resection.

J. S., 72, married, white, male, admitted to the hospital October 7, 1940, died October 10, 1940. Chief complaint, pain in the abdomen, duration five days. Abdominal distension, duration two days.

P. L.: About five days ago patient, while under treatment for what seemed to be an attack of acute bronchitis, which was characterized by frothy sputum, hacking cough and shortness of breath, complained one evening of sudden severe abdominal pain. The pain was cramp like in character, situated in the right upper quadrant, and radiated downwards to just below the level of the umbilicus and posteriorly towards

the right flank. Physician was called in and after examination, which revealed marked abdominal tenderness and some edema, morphine gr. $\frac{1}{4}$ was given. The next day the patient felt much better, the pain had completely subsided, but he complained to his son that during the early part of the morning he had felt as if something had broken inside his abdomen and the pain had been lessened. At home there was tenderness in the right side of the abdomen with marked muscle spasm and a swelling which was about the size of a large orange and very tender on pressure. There had been no temperature during this attack at any time. Patient became progressively more toxic and this morning vomited twice. He was advised to come into the hospital.

P. H.: Eighteen years ago this patient began to have bleeding from his rectum and progressive constipation which eventually made it almost impossible to have any bowel movement. He was under medical care by many physicians for over a year and then he went to New York to a specialist and a diagnosis of carcinoma of the rectum made. Patient was operated upon in this hospital for removal of this tumor mass by the Kraske operation. He has had a colostomy ever since. This colostomy functioned well for about one year after but then on one or two occasions had to be stretched because it had a tendency to close. Patient has had no symptoms referable to the gastrointestinal tract except two years after the operation when he had an attack of diarrhea which lasted for four days and was controlled by medical treatment. He worked for ten years after operation and then had to quit because of nervousness associated with the ever increasing demands of his job during the depression. About one month before this last illness he began to lose his appetite, had no desire to eat meat and lived mostly on fruit juices and beer. Patient was born in Germany but lived in this country for over fifty years.

Occupation—Foreman at the Russell Mfg. Company.

Habits—Moderate alcohol and tobacco. Appetite always good.

F. H.: Father and mother both dead, cause unknown. One sister living and well. One son and one daughter living and well. No history of any carcinoma, diabetes, tuberculosis or insanity.

System Review:

G. I.: See above for details.

G. U.: No dysuria, polyuria, no evidence of obstruction.

CVR.: No orthopnea, dyspnea, no edema, no cough.

N.M.: Normal.

P. E.: Well developed, fairly well nourished 72 year old white male appearing acutely ill and septic.

Head—Moderate alopecia, no abnormalities in contour. Eyes, pupils equal and react to light and accommodation. Sclerae normal, no injection of the vessels. No abnormal movement. Nose, negative on external examination. Ears, negative. Mouth, teeth, false, Tongue quite dry.

Neck—No adenopathy, no abnormal impulses, no masses.

Thorax—Barrel shaped. Breathing not labored, symmetrical. Heart, apex impulse in the fifth, left, intercostal space within the mid-clavicular line. No enlargements to right or left. Sounds regular of good quality. A₂ greater than P₂. Blood pressure 130/50.

Abdomen—Distended, breathing splinted. There is a colostomy opening on the left side of the abdomen to the left of the umbilicus. In the right upper quadrant there is re-

bound tenderness which extends over practically the entire upper abdomen. There is a mass which seems to consist of a coil of bowel apparently surrounded by some inflammatory mass. Over this mass there is extreme tenderness on superficial pressure. Deep pressure elicits muscle spasm. The mass is about the size of a grapefruit.

Genitalia—Negative.

Extremities—Knee jerks equal and regular.

Impression—Carcinoma of the ascending colon with ulceration. Peritoneal abscess.

Progress Notes

October 9—Patient operated on yesterday through a right upper paramedian incision. A large amount of greenish thick fecal smelling fluid evacuated and exploration of abscess cavity with finger seemed to indicate that the cavity extended under the right lobe of the liver and medially. It could not be determined whether the finger had reached as far as it could go into the abscess cavity or whether it had penetrated into the lumen of the bowel. A Penrose tube was inserted under the right lobe of the liver and one in the lower portion of the abscess cavity.

October 10—Since the last note patient has become progressively weaker. All morning he has been comatose, pulse more rapid and thready. Patient expired.

Discussion:

At this time a few remarks on the disease adenomatosis or polyposis would seem to be apropos. Most carcinomata of the large intestine originate in polyps. The potentially malignant nature of these adenomatous polyps warrants their detailed consideration because it is by the early detection of their existence, prior to malignant degeneration, and by their prompt removal that we may best expect to reduce both the incidence and the mortality of carcinoma of the large intestine. This disease runs in certain families, being inherited as a Mendelian dominant.

Rankin classifies polyps into three types or groups.

Group I—In this group are included only those growths in which the epithelium retains its normal characteristics. The tumors are usually roughly nodular, although in some specimens the surface is smooth and regular. The epithelium covering the growth and lining of the crypts is unchanged from the standard regarded as normal, but there may be in scattered areas some evidence of slight hyperplasia. Such areas are the sites of more or less inflammation secondary to the constant trauma to which these tumors in their exposed positions are constantly subjected. Polyps in this group are invariably pedunculated. According to Rankin's study, polyps of this group are destined to a long and benign course. No such pronouncement can be made, however, for the polyps of group 2.

Group II—The polyps of this group are easily distinguished from those of group 1 by the abrupt and striking structural changes in both the epithelium and connective tissue elements. The epithelium is characterized by widespread failure of the proliferating cells to differentiate completely into the units of normal intestinal mucosa. The polyps of groups 2 are also invariably pedunculated.

Two cases in the series just presented were tumors about the size of one's fist. They swung from long pedicles which made it possible for the tumors to swing out through the anal opening and then back into the rectal canal so as to make it

almost impossible for the examining finger to detect their presence. It would seem that the development of carcinoma in polyps depends on the rate at which the tumor is compelled to grow. In the slow-paced formation of group 1 there is little, if any, likelihood of cancerous change. In the relatively more rapid growths of group 2 it is a question only of time until carcinoma appears. Apparently, the intestinal epithelium cannot proliferate indefinitely, even at a moderate rate, without ultimately losing its bearings. This matter of rate of development is illustrated in the polyps of group 3.

Group III—In the polyps of this group, as in those of group 2, there has been failure of epithelium to differentiate. But in this group are only those tumors in the epithelium of which the processes of differentiation have been arrested at so early a stage that the cells have attained only the most rudimentary characteristics of the normal units of intestinal mucosa. There is thus no sharp line in separation between polyps of groups 2 and 3, as there is between polyps of groups 1 and 2. Polyps of group 3 are but accenuated forms of the polyps of group 2, in which cellular activity reaches its height for such tumors. And thus, too, there is formed a twilight zone into which may fall tumors bearing the characteristics of both groups. Although in this border zone there are not always clear cut distinctions between polyps of the two groups, yet it is useful to maintain this three-phase classification. In the older polyps of group 3, the cellular changes are advanced and unmistakable; in the younger polyps, other and secondary features of the tumors help to identify them for grouping.

It may be well to repeat, in conclusion, that the nodular polyps of group 1 pursue ordinarily a benign course; that the orderly but more rapidly growing polyps of groups 2 tend in time to malignant changes; and that formation of the order of group 3 are definitely precancerous.

Conclusion:

The case presented shows two lesions of the large intestine both polypoid in type and both malignant. It is felt that these lesions both come under the classification of Group 2 polyps which have become malignant. It is interesting to note that the first lesion was removed 18 years previous to the second lesion and at that time it was of very low grade malignancy. It is also interesting to speculate that if the remainder of the bowel had been studied the second polyp could have possibly been removed as a prophylactic measure.

Summary:

A case of 2 primary carcinomas of the large intestine was presented with an interval history of 18 years between diagnosis of the separate lesions.

Discussion of the pathology was presented.

Recommendation is made that (1) all polyps of large intestine be treated as malignant tumors; (2) that if one polyp is found others should be searched for and treated; (3) families of patients with polyposis should be examined for evidence of disease in that it is inherited as a dominant Mendelian characteristic.

It is felt that if these recommendations are followed death from carcinoma of large intestine will be less frequent than at present.

Doctor Harvey: I was very much interested the other night by the remark of an interne who said he had just clamped off a polyp and wanted permission to remove it. I found that he had a 6 year old child with a polyp the size of a finger clamped off; so we tied it off and removed it. I had never seen a polyp in a child before.

CANCER OF THE BREAST AT THE MIDDLESEX HOSPITAL

CARL C. HARVEY, M.D.

This paper discusses the radical amputations of the breast at the Middlesex Hospital between the years 1920-1937. Only cases that were verified microscopically by the pathologist are considered.

There were 60 cases of carcinoma of the breast: 5 could not be followed up, 5 had radium treatment, 3 had no treatment, and 47 had radical mastectomy.

Before I speak of the operative cases I would like to mention those not operated upon; those that received no treatment or treatment by radium. These cases were considered hopeless when first seen.

Our hospital has had 50 mgm. of radium for over a dozen years. It has been used on several cases too advanced for radical removal or who refused operation. There were five cases treated by radium alone. In the light of present radiation it was very inadequate—one, two or three thousand mgm. hours. However, let me remind you that the present treatment with massive dosage of radiation is also inadequate.

The results of these cases are interesting. I should add that these cases had no biopsy or microscopic diagnosis. My only proof that they had cancer is that they died of the disease.

Case I 68 yrs.—radium 3,600 mgm. hours—lived 3 yrs.

Case II 61 yrs.—radium 1,200 mgm. hours—lived 3 yrs.

Case III 61 yrs.—(simple mastectomy) radium 1,000 mgm. hours—lived 6 yrs.

Case IV 61 yrs.—radium 600 mgm. hours—lived 7 yrs.

Case V 85 yrs.—radium 3,000 mgm. hours—lived 5 yrs.

Three Cases received no treatment

Case I 69 yrs.—too poor condition to operate—living 2½ yrs.

Case II 43 yrs.—spinal metastasis—lived 10 months from first symptom that was not recognized for 4 months. (She was thought to have arthritis.)

Case III 78 yrs.—metastasis lung—lived 3 months.

Operative Cases

There were 15 surgeons doing these 47 radical mastectomies over a period of 17 years. This should give a large enough variety of technique for the operation, or, shall we say, surgery at its worst as well as its best. I have not been able to see that those operators who did the most operating or those whose technique I might have judged should be the best (I have seen all these men operate but one) had any better final results than the poorest. This leads me to the deduction that the important factor is not alone the technique of the surgeon, but in addition the stage of the disease and the grade of the cancer.

Unfortunately most of our carcinomas were not graded. As you know, grading has not been universally employed very many years, and the older surgeons were not very careful about dividing the cases into the different stages. In their defense, I want to say, the dividing of these cases into grades and stages has not altered the mortality rate. It has merely given us a better criterion for prognosis. The same pathologist diagnosed all these cases. The variety was in the surgery, not in the diagnosis. For the last 3 years we have been classifying our carcinomas into stages and grades, but these cases are not used in this paper. I found 21 of these cases mentioned axillary glands, that is about 50% would be placed in Stage II.

Of the 47 Operative Cases 30 or 60% died from carcinoma, 4 or 8% died from other causes, and 13 or 28% are still living.

Of the 47 Cases—28 or 60% lived 3 years, 19 or 40% lived 5 years, 8 or 17% lived 10 years, 3 or 6% lived 15 years, and 13 or 28% are still living.

Two or 4% died from the operation. I have included them in the mortality statistics.

Four died from other causes and at rather ripe old ages. I feel they should be classed as cured. They lived 12, 11½, 7½ and 4 years and died at the ages of 82, 69½, 62½ and 78. They had 35 years added to their lives. After all they had to die sometime, and they had lived their allotted span.

Of the 28% or 13 cases now living, two or 4% have evidence of metastasis. One is 56 years old and the other 65. Both have lived about 4¾ years since the operation. Eleven or 23% seem free of the disease. These 13 patients have had 113 years added to their lives, and some of them are still of middle age.

Doctors Pack and Livingston in their recent book

THE THIRTEEN LIVING PATIENTS

YEARS SINCE OP.	AGE AT OP.	AGE NOW
19	31	50
16½	33	50
15	73	88
9¾	35	45
10	74	84
10	67	77
7	67	74
5½	63	68
5	52	57
4¾	61	65
4¾	52	56
3½	40	43
3	44	47

"Treatment of Cancer and Allied Diseases" give a very interesting and instructive chart by Nathanson and Welch on the survival rate for *untreated* cases of breast cancer. Untreated cases show 3 year survival, 40%, 5 year survival, 20%, 10 year survival, 5%. If we deduct these percentages from our survival rates, we find what we have really accomplished. In 3 years we have saved 20%. In 5 years we have saved 20%. In 10 years we have saved 12%. In 15 years we have saved 6%. Pack and Livingston give a crude survival rate for unselected primary operable cases—Stage I as 40% at end of 5 years, Stage II as 38% at end of 5 years. Our survival rate in these unselected cases is 40% for 5 years.

We have felt rather modest and reluctant to present the work we have been doing in this comparatively small hospital in Middletown, yet after all, the medical and surgical work of the country as a whole has to be done in small places like ours, and perhaps a truer idea of what real medical and surgical progress is made can best be obtained from a view of small hospitals like Middlesex. Only a small part of the surgery is done in the large teaching centers, and they show us what may be done.

This hospital has been in operation 36 years. Two months ago the first person to be operated upon in the Middlesex Hospital died here. He had not been here all that time. His original operation had been an amputation at the mid thigh in 1904. He died here last October from cirrhosis of the liver at the age of 60 years. I can wish you no better success than that you (in the larger places) can have a 36 year survival of all your surgical cases.

In conclusion, perhaps I should do well to quote my old professor of surgery, Doctor Stimson of New York who was one of the founders of Cornell Medical College. He had been a surgeon in our Civil

War. He also went to France in 1914 to observe the up-to-date methods of surgical care. I once heard Doctor Stimson give a lecture on the advances and changes he had observed in surgery during his lifetime. In the Civil War, as you know, they had no aseptic surgery or no anesthesia and bacteria were still unknown. He concluded his lecture with this statement, "I shall be very pleased if you young gentlemen (and ladies) will bear an air of amiable skepticism toward anything you hear me say or anybody else."

Discussion:

Doctor Philip G. McLellan, Hartford: I enjoyed this paper and was quite impressed with the interesting presentation of the real results as compared with the course of events of what would happen. I think that you should be complimented on this paper.

CASE PRESENTATIONS

Doctor Alfred N. Sweet presented three cases of unusual tumors.

The only excuse for presentation of these cases is that in the first two cases the type of tumors are seen very infrequently and in the third, a common tumor was so located as to cause interesting neurological signs.

The first case: K. W. Age 45, Married, Admitted: Middlesex Hospital, February 3, 1937.

Provisional Diagnosis: Ganglion flexor tendon sheaths right wrist.

Chief Complaint: Lump in right wrist.

Past History: Three years ago patient was in an automobile accident in New London and received a severe fracture of right forearm, contusions and abrasions. Patient apparently made a full functional recovery from the injuries as he has full functional use of the arm. His profession requires him to spend considerable time at a drafting board making charts and graphs. The right wrist, flexor surface is in contact with the edge of the drafting board for long periods daily.

Present Illness: Six month prior to admission to the hospital, patient noticed a small lump on the ulna and flexor side of right forearm just proximal to the wrist. He did not consult a physician until three days prior to admission when he saw Doctor Fauver who referred him to me. The reason for seeking relief was that the mass was causing some discomfort rubbing on the edge of the drafting board, also he noticed a recent, fairly rapid increase in size of the mass.

Physical Examination: Essentially normal with the exception of ptosis of right eyelid which followed the automobile accident and the tumor in the wrist. The mass at the wrist was about the size of a puller's egg. Apparently this mass was attached to the flexor tendon sheaths and not to the skin or subcutaneous tissues. It had a doughy consistency and was lobulated in form. In view of the history of injury and repeated minor trauma it was felt that it probably was a ganglion, but due to morphology and consistency removal was decided upon.

At operation the mass was found to be a fairly well encapsulated and lobulated tumor of a xanthomatous color and firm consistency. It was lobulated and had some of the characteristics of a lipoma with the exception of color and consistency. The tumor extended between and beneath the flexor tendons. It was removed with considerable difficulty and with an attempt to keep the capsule intact.

Pathological Report:

Gross: Several masses look more like suprarenal tissue than fat. On section several areas show tissue which is firm and whitish pink, not incapsulated.

Diagnosis: Xanthoma.

Microscopic: Shows hemorrhage with pigmented phagocytic cells, many monocytes, oval and spindle cells. Many giant sized cells with single malignant nuclei, with many vacuoles, foamy cytoplasm. Few multinucleated giant cells.

Diagnosis: Liposarcoma.

Immediately after receiving the Pathologist's report, patient was examined for evidence of metastases. None were found and he was referred to Doctor Wilson at the New Haven Hospital for x-ray therapy.

Slides were sent with the patient and diagnosis confirmed by pathologist at the New Haven Hospital.

The patient received adequate x-ray therapy and wound healed within the normal length of time. He reported for examination once a month for a year and at the end of a year developed a mass three inches above the internal malleolus of right leg just anterior to tendon Achilles'.

This mass was excised and proved to be a simple lipoma. This wound took an abnormally long time in healing but eventually healed.

Patient was seen on December 9, 1940, following a fall and fracture of a rib. No signs of any metastases noted. He had gained 40 pounds in the past year.

At the time of operation less than 10 cases of liposarcoma were on record at Johns Hopkins Hospital.

The second case: A. DeF. White. Married. Age 34.

Chief Complaint: Mass of left knee.

Provisional Diagnosis: Cyst of left knee.

Past History: Scarlet Fever 12 years ago.

Family History: Mother had hysterectomy for tumor. Grandmother died supposedly of cancer.

Present Illness: Patient noticed a small mass on outer side of left knee for past ten to twelve years. During past year this has become considerably larger. He saw family physician who advised removal. One week before admission mass became painful and he noticed definite increase in size. Patient noticed that mass consisted of three separate parts.

Examination: Reveals a palpable mass over the tendon sheaths of external flexors of thigh about two inches above their insertion. The mass was not attached to skin or subcutaneous tissues but seemed to be attached to the tendon sheaths. No redness, local or general temperature present.

Preoperative diagnosis was cystic tumor of tendon sheaths.

Lateral incision made over mass lying just posterior to tendon of muscle. Upon going through the deep fascia, three

small masses the size of cow peas were encountered, apparently imbedded in the tendon of biceps. These were hemorrhagic and xanthomatous in color. These masses were completely excised. A large mass was then palpated lying behind the tendon sheaths. The tendon sheath was then split following the course of the tendon. A large mass about the size of a hen's egg was encountered lying beneath the sheath and extending into the popliteal space. This mass was surrounded by a very friable capsule, the external portion of which was attached to the internal portion of the tendon sheath. This part of the capsule was ruptured in freeing it from the tendon sheath and some dirty yellow very friable tissue was extruded. A line of cleavage was found about the capsule and the entire mass was dissected free keeping outside the capsule as far as possible. The tissue had the appearance of a malignant tumor. Wound was thoroughly flushed with saline and careful inspection made for any further tumor tissue. Wound then closed in layers.

Pathological Report:

Gross: Several pieces of moderately firm tissue, the total weighing 15 gms. These pieces have shaggy, irregular surfaces, no evidence of capsule, some are lobular; density varies from soft to moderately firm white with one or two areas of hemorrhage and irregular slits.

Microscopic: There are spaces lined by epithelial like cells resembling glands but showing no basement membrane, other areas show solid nests of these epithelial like cells. Mitoses are frequent. The remainder of the tissue is made up of spindle cells in some areas and dense fibrous tissue in other areas.

Diagnosis: Synovionia—malignant.

Remarks: Chest should be x-rayed and inguinal glands should be examined for evidence of metastasis. If no metastasis is evident amputation should be considered since these tumors are radio resistant. The above diagnosis has been confirmed by Doctors Tennant and Libo of the Department of pathology, Yale Medical School.

Doctor Leila Charlton Knox, Saint Luke's Hospital, New York, reported to Doctor McLeod on August 5, 1940, as follows: I have gone over the slide carefully and I believe that this is the same general type of tumor which I described in the paper in 1936, but it does not impress me as showing the fully developed signs of malignancy to the extent that our cases did. The pseudo glandular spaces are more regular, and the sarcoma like areas between them are not as cellular, nor are mitoses as frequent. I do not believe that these tumors are always of the same degree of malignancy, and I should be inclined here to be a little conservative and not to do any further operating unless a definite recurrence is observed. Even then a second biopsy might be advisable, since you think that the tumor was traumatized in removal. I am offering this opinion not because I do not believe that most of these tumors are definitely sarcomatous but because since writing the paper I have seen a number which I do not think were highly malignant and I would not wish to advise an amputation without being extremely sure of the necessity for it.

Doctor Charles F. Geschickter, Baltimore, reported to Doctor McLeod on August 8, 1940, as follows: Diagnosis: Synovial sarcoma.

Microscopic: The section shows coils and sheets of tumor cells divided by dense fibrous septa. Some of these tumor cells are epithelial in appearance and form gland-like structures. Others are packed spindle cells with deeply staining, elongated nuclei. The combination of a sarcomatous and epithelial appearance in this location is typical of synovial sarcoma.

This is a very typical case of synovial sarcoma. I would recommend amputation in the region of the mid thigh.

X-ray examination of knee joint prior to admission had been negative with the exception of soft tissue shadow. X-ray examination of the lungs was now made to determine presence or absence of metastases and the films were negative.

The question then arose as to the method of treatment. This tumor is radio resistant, therefore most authorities advise amputation. Of the twenty two cases reported in the American Journal of Cancer, Vol. XXVIII, November 1936, there were no cures reported either by radiation or amputation. The last sentence of the conclusion of the article reads, "Synovial sarcomas apparently resistant to radiation, nor have any permanent cures by amputation been recorded."

Since that article by Doctor Knox several more cases have been reported in the literature but no cures as yet.

Amputation was not performed in this case for the following reasons:

(1) The patient is a chain store manager and his duties require active ambulation during entire working day. Amputation would cause him to lose his position. Patient has a wife and two young children. Immediate loss of his earning power would be a major catastrophe.

(2) No cure has been obtained by this method.

Intensive x-ray therapy was instituted therefore instead.

The patient in the few months which has elapsed since the operation has shown no local return or metastases.

The third case: M. M. age 53. Admission to Middlesex Hospital, August 31, 1938.

Chief Complaint: Swelling of upper arm and pain extending down arm.

Family History and Past History unimportant in this case.

Present Illness: Patient has had severe pain in upper left arm for six weeks. Pain has radiated down the arm and she has noticed increasing weakness in the hand. She has also noticed a localized swelling on the outer arm just below the level of the insertion of the deltoid muscle. Pain has become so severe that patient was unable to sleep and so sought further relief.

Physical Examination: With exception of some evidence of arthritis in right hand and left upper extremity, was normal. The entire left arm was slightly cyanotic. The left arm was definitely colder than right. A mass could be palpated on the outer side of the arm at the level of the insertion of the deltoid muscle. Pressure on this mass caused transmission of pain down patient's arm, and increase in pain in the hand. Mass felt reasonably firm but not as hard as fibrous or bony tissue. Apparently was not attached to the bone and some lobulation could be felt. Weakness of grip was present in the hand. Trophic disturbance in hand in form of temperature and circulatory changes and atrophy of interosseous muscles of the hand were present.

Due to these findings the preoperative diagnosis wavered between a tumor making pressure on the nerve or a neuroma.

Operation performed on August 15, 1938, revealed a fatty tumor making decided pressure on the median nerve. This was carefully dissected away from nerve and completely excised.

Frozen section was made in operating room. Pathological report, no diagnosis.

Gross: Tissue resembles fat, though color is a bit peculiar. There was no capsule and tissue was taken out in small fragments, very friable apparently adherent to median nerve about insertion of deltoid.

Microscopic: (permanent sections)

Shows tissue composed largely of fat cells with much extravasated blood (probably operative) Connective tissue stroma greater than in simple lipoma. Vessel walls thickened. No giant cells found.

Diagnosis: Lipoma.

Within a few hours of removal the cyanosis of the arm disappeared and the temperature of the arm and hand became normal. Pain in forearm and hand was relieved. After two or three days due to oedema and oozing in the wound these symptoms returned for a few days but then disappeared.

The atrophy of the interosseous muscles and weakness in hand persisted for about six months. When examined at this time, cessation of all symptoms had occurred.

MALIGNANT NEUROFIBROMA

F. ERWIN TRACY, M.D., F.A.C.P.

This case is being presented more as a pathological monstrosity than a diagnostic problem although three different diagnoses have been made during a six year period of observation.

CASE REPORT

A. C., a 75 year old white female was sent to this hospital because of uncontrollable bleeding from a large tumor mass extending from the left temporal region of her head. The tumor was a large lobulated growth, larger than the patient's head, pink in color, with a tense shiny surface that was covered with numerous blood vessels. On palpation it felt tense and fluctuant but was not especially tender. The left side of the face and head were grossly distorted by this mass which completely obscured her left eye, obstructed the left nostril and displaced the left ear posteriorly.

This tumor was first noticed in 1933 as a small brownish nodule about the size of a pea on the left temporal region just lateral to the left eye, which, the patient stated, she used to pick at frequently. This continued to grow until in April 1934 it had attained the size of a walnut when she was advised to have it removed. She entered the Hartford Hospital at this time and the tumor was removed surgically. The diagnosis on histological sections made at that time was neurofibroma.

Shortly after her discharge from the hospital, following this first surgical removal of the tumor, there was noted by the patient a recurrence of the growth at the original site

and also a smaller daughter tumor just adjacent to this recurring tumor. These two tumors continued to grow until they again reached about the same size as the growth she had one year ago. She again entered the Hartford Hospital for treatment in August 1935. This time the recurring tumor and the slightly smaller daughter tumor were removed surgically. The diagnosis on the histological sections made at this time was neurofibroma, borderline malignancy.

The patient returned home following her second operation and soon noticed that the tumor was beginning to recur at the same original site. This time she hesitated about having another operation until November 1937 when the growth had attained the size of an orange. She again decided to have it removed. This time, however, she entered another hospital in Middletown where the growth was removed surgically and the specimen sent to the Middlesex Hospital laboratory for diagnosis. The diagnosis made from the microscopic examination at this time was malignant neurofibroma.

Following this third operation the tumor soon recurred at the same site and the patient was so discouraged she refused to undergo any further surgical procedure. In the interim she did consult a radiologist who refused to treat the tumor assuring her that radiation therapy would be of no avail. The tumor has continued to grow since it was last removed surgically in November 1937 until it now appears as you see it in this photograph.



The past history was irrelevant and there was no family history of malignancy. The physical examination, except for the tumor, previously described, revealed only emaciation, a moderate hypertension, enlarged heart and osteoarthritis of her hands and feet.

A portable roentgenological examination of her chest revealed a considerably enlarged heart but no demonstrable evidence of infiltration in either lung field.

Laboratory examinations were as follows: Urine: yellow; cloudy; specific gravity 1.012; albumin 1+; sugar-negative; hyaline casts; few epithelial and red blood cells. Blood: (11-25-40) hemoglobin 8.27 grams; red blood cells 2,128,000;

white blood cells 8,200; polynuclear 85%—lobulated 78%; nonlobulated 7%; small lymphocytes 7%; large mononuclears 8%. Blood: (12-6-40) hemoglobin 12.93 grams; red blood cells 3,550,000; Kahn reaction negative; Kline Exclusion negative; Non protein nitrogen 32 mgs.%; sugar 82 mgs.%.

The patient's course in the hospital was continually down-grade and she expired January 12, 1941. She developed a few more hemorrhages from the surface of the tumor mass which were fairly well controlled by pressing sterile gauze pads into the crevice of the tumor from which the blood oozed. No evidence of metastases was found although, unfortunately, we were unable to obtain permission for an autopsy.

Comment

Histologic sections made from the tumor masses which were removed in 1934, 1935 and 1937 had all been reviewed by our pathologist, Doctor Christie E. McLeod, and the first section was a typical neurofibroma with no evidence of malignancy. The second specimen was of borderline malignancy and the third definitely malignant. This tumor apparently fits into the group discussed by Cutler and Gross in *Treatment of Cancer and Allied Diseases—Pack and Livingstone*, Vol. III, p. 2281. They state that 15% of the cases of neurofibromata undergo malignant degeneration. The term malignant neurofibroma was adopted by them to designate those specimens which have shown a marked tendency to local recurrence and regional extension. These tumors do not exhibit a high degree of malignancy and do not metastasize by way of the blood stream or lymphatics. They produce local and regional invasions as this case illustrates. The treatment is radical local resection without attempting to separate the tumor from the nerve trunk. In activity this tumor lies halfway between a neurofibroma and a neurogenic sarcoma.

SUMMARY

A case of neurofibroma has been reported, which during the course of six years became malignant. Three surgical attempts to remove this tumor at varying intervals were unsuccessful but after each operation the tumor became more malignant. Photographs were submitted because of the unusual size and location of this malignant tumor mass.

Help Conserve Hearing

JAMES E. DAVIS, M.D., *Hartford*

According to statistics there are about fifteen million people in the United States with defective hearing. Of this number there are approximately three million children who hear less than one-half as well as the normal child. These handicapped, or

potentially handicapped, individuals make a social, economic and, in the present emergency, defense problem that deserves the attention not only of otologists, but of the whole medical profession and general public.

The prevention of deafness, especially in children, and the rehabilitation of individuals already handicapped by deafness, is a problem that cannot be solved alone by the otologist who sees only a small percentage of this army of unfortunates. The other thousands do not seek aid, either because they do not know where and what to seek, or else they have given up in hopeless despair. The first step in solving this problem is the enlightenment of the public as to the frequency and seriousness of this affliction and the methods that may be used to overcome it.

In a program of education and rehabilitation the most active agency today is The American Society for the Hard of Hearing and its chapters throughout the country. This society was founded for the mutual assistance of its members and has the distinction of being the first group of handicapped people in the history of the world to organize for its own rehabilitation. However, its help is not limited to its members, but is willingly given without charge to any individual with impaired hearing. In giving advice on the selection of hearing aids, on instruction in lip reading, and on choosing vocations for the deaf, this society and its chapters are of invaluable aid. Their ability to help solve social and economic problems outside the scope of the otologist is of immense importance.

The educative program of this society which is carried on effectively throughout the year will be intensified during National Hearing Week, October 19 to 25. During this week lectures, radio addresses, newspaper and magazine articles will combine to make the public hearing conscious and bring to the deaf the knowledge that in spite of their affliction they can still be useful citizens.

We in Connecticut are very fortunate in having three active chapters of the Society for the Hard of Hearing, Hartford, New Haven and Bridgeport. It is hoped that the medical profession will give its hearty support to the local Leagues in the excellent work they are doing in behalf of the deaf.

STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

CRIPPLED CHILDREN IN CONNECTICUT

An Analysis of the State Register

LOUIS SPEKTER, M.D., *Hartford*

SOURCE OF DATA

An analysis of the data on 1,839 crippled persons registered with the Connecticut State Department of Health is presented in the following material. The State register is a source of certain essential identification information on persons under twenty-one years of age who are still crippled. There is no law in Connecticut defining a crippled child; however, for the purpose of administering crippled children services, a crippled child is defined as an individual under twenty-one years of age, residing in Connecticut, having congenital or acquired defects which may interfere with his locomotive activities or prevent him from obtaining an education or being employed in a remunerative capacity, and having sufficient mentality to profit by treatment. No funds are spent for the treatment of hypertrophied or diseased tonsils, hernias, eye, or ear defects. The limitations of this definition are interpreted by expert medical judgment for each child requesting aid. The decision in each case is based on the type of deformity, the outlook for recovery and the likelihood of producing a self supporting citizen.

The types of crippling conditions acceptable for care are as follows:

1. *Congenital diseases.*

Congenital deformities of extremities—clubfeet or similar deformity, dislocation of hip, supernumerary fingers or toes, absence of extremity; congenital deformities of spine; harelip, cleft palate, urogenital defects, anal defects, and other deformities due to fetal disturbances; congenital heart disease.

2. *Acquired diseases.*

Deformities resulting from rickets; chronic osteomyelitis; post-polio-myelitic conditions or residual paralysis; chronic arthritis; rheumatic heart disease; bone tumors.

3. *Deformities due to trauma.*

Birth injury to nerves (requiring extended treatment), muscles (torticollis, and so forth) and bones (fractures with late deformity); burns that may lead to disabling contractures, including those requiring plastic surgery; injury with mutilation or amputation; chronic poisoning, such as lead poisoning; malunion of bones; joint injuries resulting in limitation of function.

4. *Postural defects.*

Spinal defects of severe degree due to previous disease or poor postural habits; postural ailments of the feet.

A name is removed from the register when the twenty-first birthday is reached, the crippling condition is cured, the patient moves out of the State, dies, or when the registration is made in error (i.e., not found to be a crippled child according to the Connecticut definition after adequate study). On June 30, 1940 there were 1,839 crippled children registered with the official crippled children agency. In 1939-40, 914 children received care by and were registered under the Division of Crippled Children of the Connecticut State Department of Health; by June 30, 1940, 166 were removed from the register. Of these, 23 reached the twenty-first birthday; 71 children were removed from the register because the conditions were cured; 12 children moved out of the State; 12 died; 10 were removed because the registration was made in error. Of the remaining 38, one group was clinically ineligible for registration and those in the second group were eligible but either were already under care elsewhere or were transferred to another agency for care, and therefore were registered under that agency.

Table 1 indicates the sources of information for the register. The diagnoses on the reports received by the Division of Crippled Children are made by

Chief, Division of Crippled Children, Bureau of Child Hygiene, State Department of Health

physicians and surgeons, usually specialists in their particular fields of medicine. The diagnoses of children listed as being cared for by child-placing agencies are made by the physicians giving medical care. It will be noted that by far the greater number of children registered are under the care of crippled children agencies.

TABLE I

SOURCES OF REPORTS FOR REGISTER OF CRIPPLED CHILDREN,
JUNE 30, 1940*

AGENCY	NUMBER
Anna Hadley Hakes Memorial Clinic, Winsted.....	106
Bureau of Child Welfare.....	1
Children's Hospital, Boston, Massachusetts.....	1
Children's Village, Hartford.....	28
Connecticut State Department of Health.....	748
Crippled Children's Clinic of the City of Bridgeport	244
Crippled Children's Aid Society, New Haven.....	98
Diocesan Bureau of Social Service.....	2
Hartford Dispensary.....	3
Henry Sabin Chase Memorial Dispensary, Waterbury....	2
Massachusetts General Hospital, Boston.....	1
New Haven Hospital.....	22
Newington Home for Crippled Children.....	377
St. Francis Hospital.....	1
Shriners' Hospital for Crippled Children, Springfield, Massachusetts.....	14
Stamford Hospital Cardiac Clinic.....	26
Stamford Hospital.....	1
State Tuberculosis Commission.....	4
The Seaside, Waterford.....	56
Waterbury Hospital.....	1
Private Physicians.....	103
Total.....	1,839

*Really indicates by whom crippled children are being cared; viz., all children under care of the Division of Crippled Children, State Department of Health, have been referred by physicians.

ENUMERATION OF CRIPPLED CHILDREN

The State register, started in 1939, has grown from 594 to 1,839 as of June 30, 1940. Without a doubt the number of children with crippling conditions in Connecticut exceeds the 1,839 registered. It seems safe to say the reporting from the crippled children clinics and agencies is, in general, satisfactory. There is much to be desired, however, regarding the reporting by physicians and hospitals. This is being corrected in part by the reporting of congenital abnormalities and birth injuries through the supplement to the birth certificate. How many crippled children reside in Connecticut is a matter of conjecture. According to surveys made in various parts of the United States, this may be estimated

roughly as 2.5 per 1,000 of the total population of 4,279. On the basis of 1,839 cases of crippled children reported the rate is 1.07 per 1,000 total population, and 2.78 per 1,000 population under 21 years of age.

GEOGRAPHIC DISTRIBUTION

With few exceptions crippled children are reported from every town in the State. In several of the towns where no number appears (Fig. 1) several crippled children have been reported but were removed from the register for one of the five reasons mentioned above. It will be noted that the greatest number of crippled children are grouped in and around centers where services for crippled children are available.

An endeavor was made to determine whether the rate of crippled children is the same throughout the State. For this purpose the rate per 1,000 total population and for the population under twenty-one years of age was calculated for each county (Table 2), and according to major etiologic diagnoses for each county (Table 3). The data suggest at first glance a rather wide divergence in the crippled children population in different parts of the State. There are, however, important limitations to the data which warrant our discounting any such conclusion. If children in one area are not getting care or are not being reported it will reflect in the location pattern.

It is felt that the difference in rates of crippling in each county is possibly a measure of the extent of reporting of cases; for example, in Windham County the State crippled children clinic is the only crippled children agency and probably the greatest per cent of crippled children are seen in this clinic. In counties other than Windham, it is known that children may be sent for care to agencies other than the State crippled children clinic or to neighboring states; for example, some of the children from Tolland County may go to one of the nearest State crippled children clinics, but possibly an equal number may be treated elsewhere and not be reported.

AGE DISTRIBUTION

The ages of 1,783 children on the register as of June 30, 1940 are known. These are tabulated in Tables 4 and 5, together with the etiologic diagnoses. It will be noted (Table 4) that 68 children comprising 3.8% are under one year of age; 451 or 25.2% are from one to five inclusive; 461 or 25.8% are from six to ten inclusive; 500 or 28.1% are from

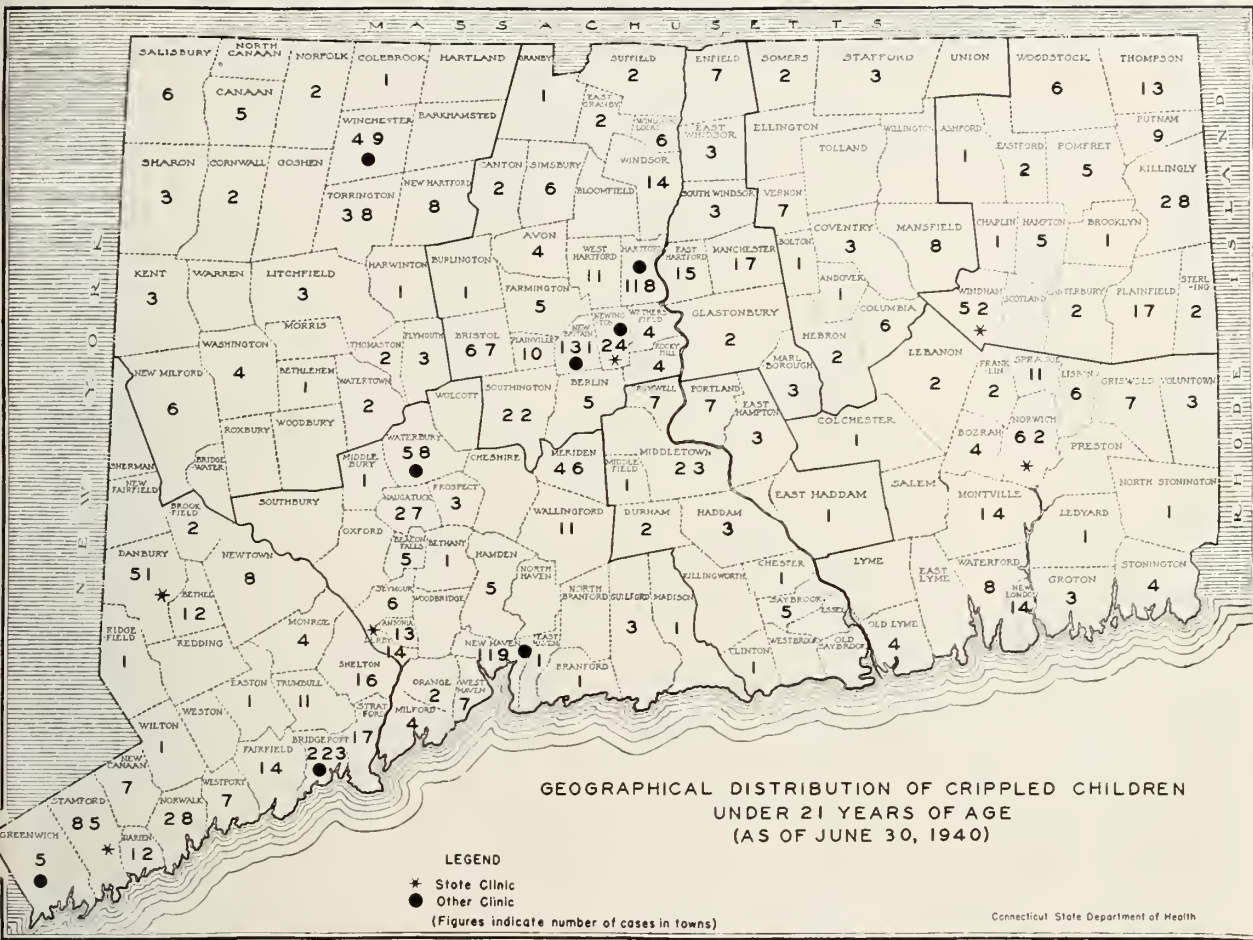


FIGURE 1

ten to fifteen inclusive; and 303 or 17% are sixteen years and over. Table 5 and Figure 2 show the age distribution of crippled children each year of age for all diagnoses, poliomyelitis, and scoliosis and kyphosis. The curve for all diagnoses remains at approximately the same level until the age of 17. It will be noted that there are relatively few registered over seventeen years of age. This is due in part to incomplete reporting, but also to the fact that many children will have been cured by the time they reach that age. The curve for poliomyelitis is at a high level at the ages eight to ten and again at fifteen to seventeen. This high level of poliomyelitis cases at eight to ten years cannot be entirely explained by previous epidemics of the disease. For instance there were 1,136 cases reported to the State Department of Health during the epidemic year of 1931. Of this number only 34 were young enough to have affected the high point of the curve. With this exception the pattern of the curve conforms with the age distri-

bution at onset of the disease as given in epidemiological reports. The configuration of the curve from year to year will depend chiefly upon the number of additional crippled children found and the cures resulting from treatment; in general, it will shift to the right. The curve for scoliosis and kyphosis reaches the highest level in the thirteen to sixteen year old group.

SEX DISTRIBUTION

There appears to be no significant difference in the sex distribution among any of the diagnostic groups (Table 6). Also, the individual diseases are approximately equally divided between both sexes with the following exceptions (Table 7). Congenital dislocation of the hip is more frequent in girls than boys, and especially is this true of scoliosis. Legg-Perthes disease, chronic osteomyelitis and pseudo-hypertrophic muscular dystrophy are found to occur more frequently in boys than in girls.

TABLE 2
DISTRIBUTION OF CRIPPLED CHILDREN BY COUNTIES, JUNE 30, 1940

	TOTAL POPULATION JUNE 30, 1940	PER CENT OF POPULATION UNDER 21 (1930 CENSUS)	ESTIMATED POPULATION UNDER 21 JUNE 30, 1940	NUMBER OF CRIPPLED CHILDREN ON REGISTER	RATE OF CRIPPLING PER 1,000 TOTAL POPULATION	RATE OF CRIPPLING PER 1,000 POPULATION UNDER 21*
Fairfield	419,121	38.2	160,104	505	1.20	3.15
Hartford	450,860	39.0	175,835	489	1.08	2.78
Litchfield	87,265	39.2	34,208	139	1.59	4.06
Middlesex	56,114	37.2	20,874	54	0.96	2.59
New Haven	484,838	39.1	189,572	328	0.68	1.73
New London	125,380	37.3	46,767	147	1.17	3.14
Tolland	31,946	38.5	12,299	33	1.03	2.68
Windham	56,276	39.3	22,116	144	2.52	6.42
State Total	1,711,800	38.7	661,611	1,839	1.07	2.78

*Based on the assumption that the proportion of the population under 21 years of age was the same in 1940 as in 1930.

TABLE 3
DISTRIBUTION OF CRIPPLED CHILDREN BY COUNTIES ACCORDING TO MAJOR ETIOLOGIC CATEGORIES, JUNE 30, 1940

ETIOLOGIC CATEGORIES	TOTAL	FAIRFIELD	HARTFORD	LITCHFIELD	MIDDLESEX	NEW HAVEN	NEW LONDON	TOLLAND	WINDHAM
Prenatal Influences	379	95	106	26	12	66	33	10	31
Infection	409	128	85	29	9	88	37	3	30
Trauma or Physical Agents	115	12	32	13	3	20	12	2	21
Circulatory Disturbances	3	0	2	0	0	1	0	0	0
Metabolism and Growth	39	12	10	1	0	7	4	1	4
New Growths	8	2	1	0	1	1	1	0	2
Unknown or Uncertain Causes*	65	17	17	3	3	12	7	2	4
Birth Injury**	243	95	56	21	13	35	11	5	7
Unknown or Uncertain Causes***	451	119	129	37	7	83	35	8	33
Undiagnosed	127	25	51	9	6	15	7	2	12
Total	1,839	505	489	139	54	328	147	33	144

*Footnote 1. Structural reaction to which is manifest. See Table 11.

**Footnote 2. Includes cerebral palsy. See Table 11.

***Footnote 3. Functional reaction to which is alone manifest. See Table 11.

RACIAL DISTRIBUTION

The white and negro races only were found on the register (Tables 8 and 9). Whether the difference in the rates per 1,000 total population and the population under twenty-one years of age between these racial groups represents the true state depends upon various factors previously discussed under the section "Geographical Distribution." No conclusions can be drawn.

DIAGNOSTIC CLASSIFICATION

The diagnoses with one exception are in accordance with the "Standard Classified Nomenclature of Disease" (Table 10). The exception to this is the

diagnosis of cerebral palsy which will be discussed later. No patient is listed for more than one diagnosis, only the principal diagnosis being used if more than one clinical condition is presented in the same case. Eighteen cases of congenital heart disease and seventy-eight cases of rheumatic heart disease are included in this data.

In Table 11 are grouped the diagnoses according to the etiological classification used in the "Standard Classified Nomenclature of Disease." Birth injury was added as a separate group.

Placing torticollis under prenatal influences may be questioned. Many cases undoubtedly could be placed under birth injury.

TABLE 4
DISTRIBUTION IN AGE PERIODS ACCORDING TO MAJOR ETIOLOGIC CATEGORIES, JUNE 30, 1940

AGE	TOTAL	PRENATAL INFLUENCES	INFECTION	TRAUMA OR PHYSICAL AGENTS	CIRCULATORY DISTURBANCES	METABOLISM AND GROWTH	NEW GROWTHS	UNKNOWN OR UNCERTAIN CAUSES*	BIRTH INJURY**	UNKNOWN OR UNCERTAIN CAUSES***	UNDIAGNOSED
Under 1	68	47	2	2	0	1	0	1	8	3	4
1 through 5	451	133	37	11	0	21	2	7	70	129	41
6 through 10	461	79	127	24	2	10	1	17	58	108	35
11 through 15	500	69	139	40	1	5	2	26	60	131	27
16 through 20	303	37	95	35	0	1	3	12	35	65	20
Sub Total	1,783	365	400	112	3	38	8	63	231	436	127
Age unknown	56	14	9	3	0	1	0	2	12	15	0
Total	1,839	379	409	115	3	39	8	65	243	451	127

*Footnote 1 } See Table 3
**Footnote 2 }
***Footnote 3 }

TABLE 5

AGE DISTRIBUTION OF ALL CHILDREN REGISTERED AND FOR CHILDREN WITH POLIOMYELITIS, SCOLIOSIS AND KYPHOSIS, JUNE 30, 1940

AGE	SCOLIOSIS AND KYPHOSIS					
	ALL DIAGNOSES	PER NUMBER	POLIOMYELITIS	PER NUMBER	AND KYPHOSIS	PER NUMBER
0	68	3.8	....	....	1	0.7
1	66	3.7	1	.5	1	0.7
2	95	5.3	1	.5	2	1.4
3	109	6.1	4	1.8	1	0.7
4	90	5.1	4	1.8	0	....
5	91	5.1	7	3.2	2	1.4
6	80	4.5	6	2.8	3	2.1
7	68	3.8	9	4.1	2	1.4
8	101	5.7	14	6.4	7	5.0
9	92	5.2	19	8.7	5	3.6
10	120	6.7	28	12.8	4	2.9
11	96	5.4	20	9.2	11	7.9
12	96	5.4	11	5.0	7	5.0
13	102	5.7	13	6.0	16	11.4
14	101	5.7	13	6.0	15	10.7
15	105	5.9	15	6.9	18	12.9
16	88	4.9	14	6.4	12	8.6
17	78	4.4	20	9.2	11	7.9
18	69	3.9	9	4.1	10	7.2
19	36	2.0	3	1.4	8	5.7
20	32	1.2	7	3.2	4	2.9

Total known ages 1,783 218 140
Total cases 1,839 220 144

AGE DISTRIBUTION OF CRIPPLED CHILDREN IN CONNECTICUT (AS OF JUNE 30, 1940)

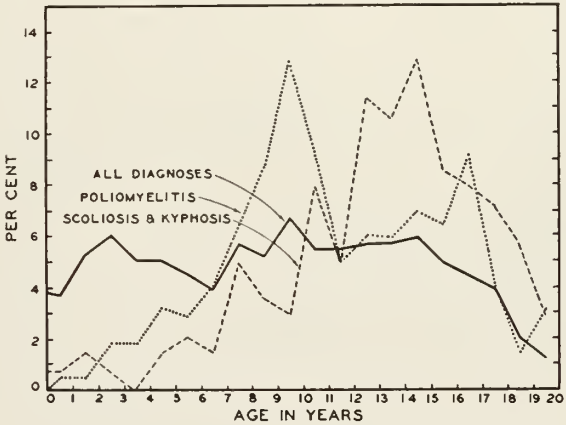
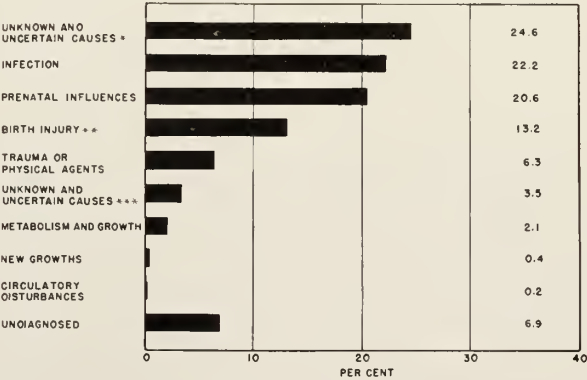


FIGURE 2 CONNECTICUT STATE DEPARTMENT OF HEALTH

CAUSES OF CRIPPLING CONDITIONS IN CRIPPLED CHILDREN UNDER 21 YEARS OF AGE IN CONNECTICUT (AS OF JUNE 30, 1940)



* Structural reaction to which is manifest.
** Includes cerebral palsy.
*** Functional reaction to which is alone manifest.

Connecticut State Department of Health

FIGURE 3

TABLE 6

SEX DISTRIBUTION ACCORDING TO MAJOR ETIOLOGIC CATEGORIES,
JUNE 30, 1940

ETIOLOGIC CATEGORIES	TOTAL	MALE	FEMALE
Prenatal Influences	379	191	188
Infection	409	207	202
Trauma or Physical Agents	115	59	56
Circulatory Disturbances	3	2	1
Metabolism and Growth	39	19	20
New Growths	8	4	4
Unknown or Uncertain Causes*	65	40	25
Birth Injury**	243	127	116
Unknown or Uncertain Causes***	451	202	249
Undiagnosed	127	61	66
Total	1,839	912	927

*Footnote 1

**Footnote 2 } See Table 3

***Footnote 3 }

TABLE 7

SEX DISTRIBUTION OF CERTAIN DISEASES, JUNE 30, 1940

DISEASE	NUMBER OF CASES		
	TOTAL	MALE	FEMALE
Congenital dislocation of hip	35	8	27
Osteochondrosis of capital epiphysis of femur (Legg-Perthes)	22	16	6
Osteomyelitis, chronic	22	15	7
Pseudohypertrophic muscular dystrophy	17	12	5
Scoliosis	108	15	93

TABLE 8

RACIAL DISTRIBUTION ACCORDING TO MAJOR ETIOLOGIC
CATEGORIES, JUNE 30, 1940

ETIOLOGIC CATEGORIES	TOTAL	RACE		
		WHITE	COLORED	UNKNOWN
Prenatal Influences	379	327	4	48
Infection	409	363	12	34
Trauma or Physical Agents	115	103	3	9
Circulatory Disturbances	3	3	0	0
Metabolism and Growth	39	30	4	5
New Growths	8	7	0	1
Unknown or Uncertain Causes*	65	58	1	6
Birth Injury**	243	211	5	27
Unknown or Uncertain Causes***	451	362	9	80
Undiagnosed	127	115	2	10
Total	1,839	1,579	40	220

*Footnote 1

**Footnote 2 } See Table 3.

***Footnote 3 }

TABLE 9

RACIAL DISTRIBUTION OF CRIPPLED CHILDREN, JUNE 30, 1940

RACE	POPULATION		NUMBER OF CRIPPLED CHILDREN	RATE PER 1000 POPULATION IN EACH RACIAL GROUP	
	TOTAL	UNDER 21		TOTAL	UNDER 21
White	1,679,601	649,682	1,579	1.047	2.760
Negro	31,275	11,750	40	1.471	3.915
Total	1,711,800	661,611	1,619*	1.074	2.780

*Does not include 220 cases in which race was not known.

TABLE 10

DIAGNOSTIC CLASSIFICATION OF CRIPPLED CHILDREN,
JUNE 30, 1940

Abnormal posture (not flat feet).....	54
Absence, congenital, of coccyx.....	1
Absence, congenital, of extremity.....	6
Accessory digit	2
Accessory scaphoid	6
Achondroplasia, complete	1
Adduction, forefoot	13
Amputation, posttraumatic	11
Amyotonia, congenita	1
Ankylosis of hip.....	2
Arachnoiditis	1
Arthritis, rheumatoid	24
Arthritis, tuberculous	1
Arthritis, cause not determined.....	5
Arthrogryposis multiplex congenita.....	2
Atelectasis, right lung	1
Avulsion of epiphyses of femur or radius.....	8
Birth injury, laceration of facial nerve.....	3
Birth injury, laceration of spinal cord.....	1
Burn, electric	1
Cerebral palsy—monoplegia	12
Cerebral palsy—paraplegia	30
Cerebral palsy—hemiplegia	55
Cerebral palsy—triplegia	2
Cerebral palsy—quadriplegia	14
Cerebral palsy—athetosis	14
Cerebral palsy—ataxia	1
Cerebral palsy—mixed type	4
Cerebral palsy—unspecified	34
Chorea	4
Chronic bursitis, posttraumatic.....	2
Cicatrix of skin, due to burn	18
Cicatrix of skin, posttraumatic	2
Cleft palate, with or without harelip.....	57
Compression of nerve.....	1
Congenital atresia of anus, complete.....	1
Contracture, due to infection.....	4
Contracture, due to trauma.....	6
Contracture, ischemic, (Volkmann's).....	3
Contracture, cause not determined.....	1
Coxa vara or valga.....	6
Cyst of bone (meniscus of knee).....	1
Cyst of femur.....	1
Deformities, congenital, multiple.....	10
Deformity, congenital, of arm	3

TABLE 10 (Continued)

Deformity, congenital, of face	1	Multiple sclerosis	3
Deformity, congenital, of finger	7	Myositis ossificans	1
Deformity, congenital, of foot	1	Neuritis of facial nerve, due to infection.....	1
Deformity, congenital, of hand	7	Obstetrical paralysis	72
Deformity, congenital, of leg	1	Occlusion of ureter, congenital, partial.....	2
Deformity, congenital, of ribs	1	Osteochondritis of hip.....	1
Deformity, congenital, of toes	8	Osteochondritis (unspecified)	1
Deformity of hip, postoperative.....	1	Osteochondroma	3
Deformity of sternum, due to rickets.....	3	Osteochondrosis of capital epiphysis of femur (Legg-Perthes)	22
Deformity, posttraumatic	15	Osteochondrosis of cuneiforms	1
Detachment of medial meniscus of knee.....	1	Osteochondrosis of ilium	1
Dislocation, congenital, of hip.....	35	Osteochondrosis of navicular (Koehler)	2
Dislocation of cervical vertebrae.....	1	Osteochondrosis of os calcis	1
Dislocation of hip, due to infection.....	1	Osteochondrosis of tuberosity of tibia (Osgood-Schlatter)	1
Dislocation of joint.....	5	Osteochondrosis of vertebrae	7
Dislocation of meniscus of jaw.....	1	Osteomyelitis, chronic	22
Epiphysis, slipping of, post-infectious.....	1	Paralysis agitans	1
Epiphysitis, posttraumatic	3	Periostitis of lumbar spine.....	1
Exostoses of foot, due to pressure.....	1	Polioomyelitis	220
Exostoses of os calcis.....	2	Pronation	186
Exostoses of scaphoids, due to trauma.....	1	Pseudohypertrophic muscular dystrophy.....	17
Failure of segmentation, syndactylism.....	3	Rickets	31
Flat foot, spastic	1	Scaphocephaly, congenital, of skull.....	1
Fracture and fracture malunion.....	13	Scapula, congenital elevation of.....	6
Ganglion of tendon sheath.....	4	Scoliosis	123
Genu valgum or valgus.....	20	Segmentation, incomplete, synostosis, of radius and ulna	4
Genu varum	29	Short achilles tendon (cause unknown).....	1
Growth, arrest of, of femur (following fracture).....	1	Spina bifida	27
Harelip, without cleft palate.....	5	Spondylolisthesis	1
Heart disease, congenital.....	18	Sprain of ankle.....	4
Heart disease, rheumatic.....	78	Sprain of finger.....	1
Hemangioma of foot.....	1	Synostosis of cervical vertebrae.....	2
Hemarthrosis of knee, due to hemophilia.....	1	Synovitis, chronic, of knee.....	1
Hemivertebra	2	Syringomyelia	1
Hereditary sclerosis, spinal form (Friedreich).....	2	Talipes, congenital (including club-foot).....	87
Hydrarthrosis, intermittent	2	Teratoma of spinal cord.....	1
Hydrocephalus	2	Tibial torsion	3
Hypertrophy, congenital, of extremity.....	3	Toe, hammer	2
Hypertrophy, congenital, hemi.....	1	Torticollis, congenital	45
Hypoplasia, congenital, of leg.....	2	Tuberculosis of elbow	2
Hypospadias	4	Tuberculosis of forearm	1
Injury of extremity, posttraumatic.....	6	Tuberculosis of hip	18
Injury of leg, gun-shot wound.....	2	Tuberculosis of humerus and ulna.....	1
Injury of shoulder, posttraumatic.....	1	Tuberculosis of knee	4
Injury of skull, posttraumatic.....	1	Tuberculosis of rib	1
Kyphosis (round back)	21	Tuberculosis of vertebra and spine.....	16
Laceration of brain.....	1	Tumor (arm)	1
Laceration of ulnar nerve.....	1	Wound of nerves, postoperative.....	2
Lymphangioma of neck	2	Diagnosis deferred	127
Meningocele	1		
Metatarsus varus, congenital.....	2		
Micrognathia	1	Total	1,839

One may question the small number of cases of rickets. Cases of knock-knees, bowlegs, pronation, postural abnormalities, scoliosis and kyphosis may result from rickets, but are not recorded as such. The State cases were diagnosed as rickets when there

was no doubt as to the etiology, and rachitic signs were present in other parts of the body. There were several instances of rickets in children seen at the State clinics, but these were not recorded as rickets in those cases where it had no relation to the chief

crippling condition.

Attention should be called again to the fact that the term cerebral palsy is used. This term is used because it embraces similar clinical entities, although the etiology may be different and the pitfalls in making etiological diagnoses are too many. Cerebral palsy is listed under birth injury. Perhaps it might well have been placed under prenatal influences. If prenatal, birth and neonatal records were available in each reported case, the etiology perhaps could be determined with a fair degree of accuracy. Without such data, which infrequently is available in the clinics, an etiological classification would be unwarranted. All cases are placed under birth injury to call attention to the factor of injury (whether this resulted from a massive intracranial hemorrhage or diffuse cerebral injury following asphyxia).

Figure 3 presents graphically the percentage distribution according to etiology. There are two groups of unknown and uncertain causes: The larger group, representing 24.6% of all the diagnoses, is known as Group x of the "Standard Classified Nomenclature of Disease" and refers to such conditions as abnormal posture, genu varum and valgum, pronation, and scoliosis and kyphosis (Table 11). The smaller group, 3.5% of unknown and uncertain causes, is Group 9 and includes such conditions as muscular dystrophy and osteochondrosis (epiphyseal disturbances) (Table 11).

AGE OF ONSET

The ages of onset of crippling conditions may be seen in Table 12. These were known in 1,273 cases or 69.2% of the total cases registered. It will be noted (Table 12) that in 697 cases or 54.7%, the condition was present during the first year of life; in 268 cases or 21%, the onset occurred during the ages of one through five. It is evident, therefore, that 75.7% of crippling conditions may be discovered in preschool children.

Figure 4 shows the distribution of age of onset for each year of age of all diagnoses, poliomyelitis, and scoliosis and kyphosis.

The high level for all diagnoses during the first few years of life is accounted for by the congenital anomalies and birth injuries. The curve for scoliosis and kyphosis in contrast to that for poliomyelitis and all diagnoses shows a sudden rise at nine and drops to the former level at fifteen. The high incidence of such defects at these ages suggests the value of a program for prevention and correction of poor posture carried on during early school years.

TABLE 11
DIAGNOSES GROUPED ACCORDING TO ETIOLOGY, JUNE 30, 1940

	SUB-TOTALS GROUP	
Diseases due to prenatal influences.....	379	
Absence of a part.....		7
Brain and spinal cord abnormalities (includes spina bifida)		30
Cleft palate with or without harelip.....		57
Club-foot		67
Deformity of extremity.....		62
Dislocation of joint (chiefly hip).....		40
Harelip without cleft palate.....		5
Hypertrophy or hypoplasia of part.....		6
Multiple anomalies		3
Segmentation defects		9
Supernumerary part		8
Torticollis		45
Urogenital abnormalities		6
Other		34
Diseases due to lower plant and higher plant and animal parasites	409	
Arthritis (non-tuberculous)		29
Osteomyelitis		22
Poliomyelitis		220
Tuberculosis of bones and joints.....		46
Other		92
Diseases due to trauma or physical agents.....	115	
Amputation		11
Deformity due to burn		19
Deformity due to trauma		53
Injury to nerve or brain (other than birth injury)		14
Other		18
Diseases secondary to circulatory disturbances	3	
Volkmann's contracture		
Diseases due to disorders of metabolism, growth, or nutrition	39	
Postrachitic conditions		34
Others		5
New growths	8	
Diseases due to unknown or uncertain causes, the structural reaction (degenerative, infiltrative, inflammatory, proliferative, sclerotic, or reparative) to which is manifest; and hereditary and familial diseases of this nature	65	
Muscular dystrophy		17
Osteochondrosis (epiphyseal disturbances)		37
Other		11
Birth injuries	243	
Cerebral palsy		167
Flaccid paralysis (brachial)		72
Other		4
Diseases due to unknown or uncertain causes, the functional reaction to which is alone manifest; hereditary and familial diseases of this nature	451	
Abnormal posture		54
Genu varum and valgum.....		49
Pronation		200
Scoliosis and kyphosis.....		144
Other		4
Undiagnosed diseases	127	
Total	1,839	1,839

TABLE 12

ONSET IN AGE PERIODS OF CRIPPLING CONDITIONS ACCORDING TO MAJOR ETIOLOGIC CATEGORIES, JUNE 30, 1940

AGE AT ONSET	TOTAL	PRENATAL INFLUENCES	INFECTION	TRAUMA OR PHYSICAL AGENTS	CIRCULATORY DISTURBANCES	METABOLISM AND GROWTH	NEW GROWTHS	UNKNOWN OR UNCERTAIN CAUSES*	BIRTH INJURY**	UNKNOWN OR UNCERTAIN CAUSES***	UNDIAGNOSED
Under 1	697	379	27	6	0	5	4	8	220	28	20
1 through 5	268	0	144	22	2	8	0	7	6	59	20
6 through 10	144	0	69	19	1	0	0	7	2	40	6
11 through 15	150	0	43	22	0	1	0	17	0	42	15
16 through 20	14	0	8	7	0	0	0	3	0	3	3
Sub Total	1,273	379	291	76	3	14	4	42	228	172	64
Age at onset unknown	566	0	118	39	0	25	4	23	15	279	63
Total	1,839	379	409	115	3	39	8	65	243	451	127

*Footnote 1

**Footnote 2

***Footnote 3

} See Table 3.

TABLE 13

NUMBER AND PERCENTAGE OF CRIPPLED CHILDREN IN EACH DIAGNOSTIC GROUP, BY STATES; CRIPPLED CHILDREN ON STATE REGISTERS, DECEMBER 31, 1939*

STATE	TOTAL	POLIO MYELITIS PER CENT	CEREBRAL PALSY PER CENT	OTHER BIRTH PARALYSES PER CENT	CLUB-FOOT PER CENT	HARELIP OR CLEFT PALATE PER CENT	TUBERCULOSIS OF BONES AND JOINTS PER CENT	OSTEO MYELITIS PER CENT	SCOLIOSIS PER CENT	RICKETS PER CENT	BURNS PER CENT	ALL OTHERS PER CENT	PROVISIONAL DIAGNOSES PER CENT
Connecticut	1,228	12.3 (12) **	10.0 (9.1)	6.5 (4.1)	2.6 (3.6)	4.2 (3.3)	3.1 (2.5)	1.3 (1.2)	6.8 (7.8)	0.9 (1.8)	1.1 (1)	47.5 (46)	3.7 (6.9)
Maine	2,301	15.5	9.0	3.0	6.9	2.4	2.9	3.6	4.1	4.7	1.4	45.8	0.7
Massachusetts	5,473	38.1	12.1	6.9	2.9	1.3	9.8	3.0	2.4	1.0	0.8	20.9	0.8
New Hampshire	1,485	17.8	5.2	4.4	4.9	2.4	3.3	3.1	5.2	4.1	0.7	43.2	5.7
New York	29,849	25.2	9.4	2.2	4.2	2.7	3.3	3.3	5.8	4.9	1.1	28.6	9.3
Rhode Island	1,930	29.7	10.2	7.2	5.3	1.3	5.9	5.2	2.4	3.6	0.3	24.9	4.0
Vermont	1,252	21.7	10.3	2.8	5.9	3.0	1.8	1.5	6.5	1.8	0.8	43.9	....
Total, 45 States	248,627	19.2	10.2	2.4	7.3	4.4	3.8	5.9	3.6	3.0	2.2	35.7	2.3

*Social Statistics, Supplement No. 4, June 1940, The Child, Vol. 4, No. 12, Children's Bureau, United States Department of Labor.

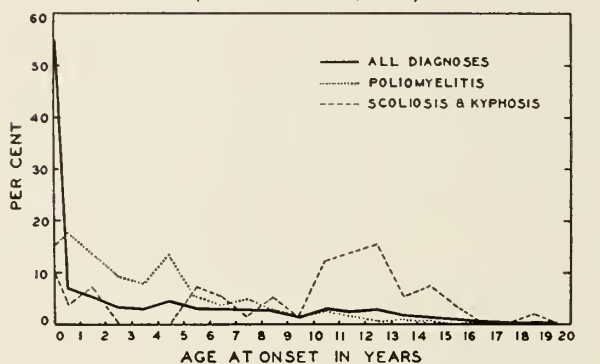
**Numbers in parentheses indicate per cent of registered crippled children as of June 30, 1940, numbering 1,839 cases.

NUMBER AND PERCENTAGE OF CRIPPLED CHILDREN IN DIAGNOSTIC GROUPS, BY STATES

The types of crippling conditions treatable (as of June 30, 1940), and the upper age limit of children acceptable for treatment in the State crippled children programs of the New England states and New York state are similar, except that heart disease

is included in the Connecticut program but not in those of the other states.

It is interesting to compare the number of crippled children and percentage of crippled children in each of several diagnostic groups in the United States and in the states close to Connecticut (Table 13). It will be noted that there is little difference between the

AGE AT ONSET OF CRIPPLING CONDITIONS IN CONNECTICUT
(AS OF JUNE 30, 1940)

CONNECTICUT STATE DEPARTMENT OF HEALTH

FIGURE 4

Connecticut percentages of December 31, 1939, and June 30, 1940, even though there was an addition of 611 cases to the register during the six-month interval.

The assistance of Mrs. Evelyn S. Novak and Mr. Edwin T. Tracy is gratefully acknowledged.

Fall County Association Meetings

Fairfield—October 1—Woodway Country Club, Springdale.

4:30 P. M. Business Meeting.

6:30 P. M. Dinner—Guest speaker, Doctor Eugene La Forest Swan, Brooklyn. Subject: "Emotional Problems of Children."

Hartford—October 28—Chippabee Country Club, Bristol.

4:30 P. M. Business Meeting.

6:30 P. M. Dinner. Speaker to be announced.

Litchfield—October 7—Doctor Hanchett's camp, Bantam Lake.

Middlesex—October 9—Place and speaker to be announced.

New Haven—October 23—Place and speaker to be announced.

New London—October 2—Uncas-on-the-Thames, Norwich.

4:30 P. M. Business Meeting.

6:30 P. M. Dinner. Guest speakers, Doctors Irving J. Walker and Franklin W. White, Boston. Subject: "Intestinal Obstruction."

Tolland—October 21—Place and speaker to be announced.

Windham—October 16—Place and speaker to be announced.

The Health of the Negro Sharecropper in the South

An interesting as well as enlightening controversy has appeared dealing with the health of the Negro sharecropper. J. W. Thompson in the *Journal of the American Medical Association* for July 5 reports in detail the results of a clinical study of a small group of Negro sharecroppers on a Mississippi plantation. This study would seem to dispel the prevalent opinion that the health of these black people is lamentably poor. The writer even goes so far as to state that "the physical status, apart from gonococcic infections, of the plantation Negro is, at least in certain areas, not far below the standard of excellence in a white group." This white group was composed of a selected number of Harvard students.

Apparently Doctor Thompson has so far over done his job that it has created a reaction within medical circles in the South. Even though 80 years have passed since the War Between the States began, it still seems difficult for the Yankee of New England to understand his Southern brother in the lowlands of the Mississippi River. The editor of the *North Carolina Medical Journal* expresses it in masterful terms when he says:

"Madame Perkins, too, has bemoaned the condition of the Southern farm laborer in her most sanctimonious New England accent, and for the past eight years Northern audiences have flocked to the obscenities of "Tobacco Road" under the impression that here, at last, was a true picture of the South, stripped of the Thomas Nelson Page type of romanticism."

The North Carolina editor, at least, is not to be deceived by the report of the Boston scientist. The health of the Negro sharecropper apparently is not all that they think it is on Beacon Hill and there is still much to be done on the Mississippi plantations in order to attain an enviable health record among the Negroes.

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EDITORIALS

An Editorial by the President

It is my object in this short message to the physicians of Connecticut to arouse and encourage their patriotism into a realization of the necessity for our continued efforts in the field of preparedness and defense.

The Connecticut State Medical Society, through its Committee on Medical Preparedness, started its planning when the first faint clouds of war appeared more than a year ago. Its first objective was the organization and the continued operation of the Selective Service. Nearly 400 of our physicians are voluntarily serving in this important function as others are throughout the nation. It is an arduous and time consuming task which may not seem to be appreciated, but the country is deeply indebted to these men for their services. How long the operation of the draft may continue no one can say, but it is safe to believe that, no matter how long it will be, medicine will be ever willing to do its part.

Many members of the Society are serving in the Army and Navy and other government services. As time goes on more will be called to the colors. For some it is an adventure, but for most it is being done

at great personal sacrifice, a realization of which should bring to us who are going comfortably along our well ordered way, a willingness to assume the tasks that present themselves on the home front.

There is much to be done, whether or not we regard danger to the lives and property of our people as imminent. Perhaps "it can't happen here," but America must make quite sure.

JAMES DOUGLAS GOLD.

Meet the Bride and Groom

This year Ohio and Massachusetts have enacted legislation requiring some form of premarital examination and increasing to twenty one the number of states in this category. Because of the striking difference in the recently enacted premarital laws in these two States, a comparison should be of value to the thoughtful physician. Ohio's new law, effective August 18, requires each applicant for a marriage license to furnish a physician's statement, *rendered after an appropriate medical examination*,¹ to the effect that such applicant is not infected with

1. Ohio State Med. Jour., Aug. 1941—Digests of Important Medical and Health Laws.

syphilis, or, if so infected, is not in a stage of that disease which is communicable or likely to become communicable. Obviously this law is designed primarily to prevent the marriage of a person having syphilis in a communicable stage and in order to meet the requirements of the law more than the taking of a specimen of blood for a standard test for syphilis must be included. It leaves to the physician's own judgment just how thorough or extensive shall be this examination but, as has been found true in other States, the success or failure of this law depends on the thoroughness of the physician consulted by the prospective bride or groom.

Governor Saltonstall of Massachusetts recently signed a premarital examination law passed by that Legislature which leaves nothing to the imagination but requires that a registered practitioner of medicine shall *examine* each of the prospective candidates. Note the wording of the law: "If such physician, in making such examination, discovers evidence of any infectious disease declared by the state department of public health to be dangerous to the public health, he shall inform both parties of the nature of such infectious disease and of the possibilities of transmitting the same to his or her marital partner or to their children. Such examination shall include a standard serological test for syphilis . . ."²

As we have previously remarked,³ Connecticut congratulates itself on being among the first States to pass a premarital examination law. Our law requires "a statement or statements signed by a licensed physician that each applicant has submitted to a Wasserman or Kahn or other similar standard laboratory test and that, in the opinion of such physician, the person is not infected with syphilis or in a stage of that disease that may become communicable and such statements shall be accompanied by a record of the standard laboratory tests made . . ."⁴ Few physicians in this State have read the text of the law, otherwise they would not content themselves with merely taking a specimen of blood for a standard serological test for syphilis.

Some form of an examination is necessary in order to detect the early Wasserman or Kahn negative case of syphilis. What better opportunity to do a thorough job and give the prospective bride or groom the physical examination that should be completed at this time? The unhappiness experienced by

newly married couples due to difficulties arising because of ignorance may be prevented by the giving of proper advice at the time of the premarital examination. Like the Ohio law, the Connecticut law leaves much to the physician's coöperation and judgment. The law has accomplished much in this State, but should each physician avail himself of his opportunity and make a complete physical examination instead of simply taking a specimen of blood he will be rendering a service to the prospective bride and groom which will reach much beyond the mere eradication of syphilis. This is an age of preventive medicine. The premarital examination carried out in a thorough manner may establish the habit of an annual physical examination and become one of the strongest links in the program of preventive medicine.

The Treatment of Prostatic Hypertrophy With Sex Hormones

The rationale for the treatment of prostatic "hypertrophy" with hormones should be based on the reaction to these hormones of the fundamental tissues from which the tumor derives its origin. The common lesion generally termed prostatic "hypertrophy" develops from the fibromuscular and ductal tissues of the posterior urethra. Research has proved beyond a doubt that the tissues of the posterior urethra, prostate, and seminal vesicles are sensitive to both male and female hormones. The use of the male hormone for the treatment of prostatic hypertrophy has been advocated for several years but with conflicting results. The female hormone is now likewise being used by the "trial and error" method. An evaluation of the effects of these hormones on the tissues of the internal genitalia of the male will help to govern the use of these hormones.

The effect of the male hormone on the prostate has been demonstrated in several ways. Numerous authors have shown that castration of young and middle-aged rats and monkeys is followed by atrophy of all the internal genitalia. Eunuchs who have been castrated early in life have never been known to develop prostatic "hypertrophy." Castration of the human after prostatic "hypertrophy" is well developed does not alleviate the symptoms produced by the tumor, nor is there a subsequent reduction in the size of the tumor. There are many reports that the use of testosterone has failed to reduce the size of the prostatic gland after it has once become enlarged. Many reports show a tem-

2. Mass. House Bill No. 460, Sect. 20B.

3. Edit., Conn. State Med. Jour., May 1940.

4. Conn. Gen. Statutes, Sec. 1595, Par. (b).

porary improvement in the well-being of the individual, caused by an increase in general muscular tone. On the contrary, treatment with testosterone reduces spermatogenesis and, in some cases, causes complete aspermatogenesis, signifying an adverse effect on the testicle. Thus the testicular hormone affects the normal tissues of the prostate in a definite manner, while the tissues which compose the prostatic "hypertrophy" are unaffected.

Old dogs are known to develop benign enlargement of the prostate. The pathology of the benign prostatic tumor of the dog is different from that of the benign prostatic tumor in man. In the canine, the tumor resembles an adenoma, while in man it is not an adenoma but a multiplication of the normal tissues of the prostatic gland. Castration of the dog does not reduce the tumor and cause a cessation of urinary symptoms. Enlargement of the prostate in dogs has been produced by several experimenters with the use of male hormone. Hence we have both clinical and experimental data which leads us to conclude that the benign prostatic tumor in the dog is closely related to the testicular hormone. Thus we must not only recognize that the histological structure of the prostatic tumor in man and dog differ but that the response to the male sex hormone is different. We can also conclude that the factor or factors which cause prostatic "hypertrophy" to develop in the dog are different from those which cause the development of the tumor in the human being.

Prostatic "hypertrophy" develops in elderly individuals when sex life becomes less rigorous and the external sex organs begin to show some atrophy. It is fair to believe that there has developed an imbalance of the male and female hormones. For this reason, and because the use of the male sex hormone fails to control prostatic "hypertrophy" in man, it is logical to turn to the use of the female hormone. The administration of estrone to monkeys and rats produces in the posterior urethra greatly thickened epithelium which becomes squamous and cornified. Fibromuscular tissue develops around the urethra, and there is an increase in the fibromuscular stroma of the seminal vesicles with a definite diminution of glandular tissue in the prostate and seminal vesicles.

The so-called prostatic hypertrophy in man begins as a fibromuscular nodule in the muscular wall of the posterior urethra. Recently, several experimenters have produced fibromuscular nodules in the uterus of guinea pigs by the injection of the female

hormone. These lesions are similar to the primary lesion of the prostatic tumor in man. We have evidence of fibromuscular development produced by a similar hormone in the fibro-adenoma of the breast and, still further, in the enlargement of the lower ureter and trigone which occurs during pregnancy. We may state with a fair degree of certainty that benign prostatic "hypertrophy" in man begins as a fibromuscular nodule which derives its origin from the muscle tissue of the posterior urethral wall. The glandular tissue element in prostatic "hypertrophy" derives its origin from the epithelium of the ducts of the prostate. The factor or factors deliberately responsible for these tissue growths is unknown, although it is assumed to be hormonal. Both the fibromuscular and glandular tissues take their origin from tissues of the posterior urethra. Both the male and the female hormones produce tissue growth in the posterior urethra and prostate. The female hormone stimulates the growth of fibromuscular tissue which simulates the tissue of the primary benign prostatic tumor. The glandular tissue of the normal prostate is responsive to testicular hormone, while there seems to be little evidence that the glandular tissue of the benign tumor is responsive to the administration of the male hormone. As yet, prostatic "hypertrophy" with the same histopathological character as the fully developed tumor found in man has never been produced experimentally in man or animal.

It is difficult, then, to support the rationale of treating prostatic "hypertrophy" with either the male or female sex hormone. Theoretically, prostatic "hypertrophy" may be the result of an imbalance of these two hormones. We do not have any practical clinical method for the determination of the imbalance of these hormones. The only clinical evidence of hormonal influence on prostatic "hypertrophy" lies in the fact that castration early in life will prevent its development. Therefore, the treatment of prostatic "hypertrophy" in man with either sex hormone does not seem justified at the present time.

The New School of Nursing

Any program which may add to the professional equipment of the physician or the nurse and thus enhance the practice of medicine should be aided and abetted, especially in its early struggling period. In this issue of the *Journal* in the section on Public Affairs appears a description of the new graduate

school of nursing established at the University of Connecticut. At the present time should a registered nurse wish to take graduate work and fit herself for some special field of nursing, she must go out of the State to one of our large universities and carry on there at considerable expense. With the establishment of this new in-service training program leading to a bachelor's degree in our own State University the problem becomes much less difficult because of the accessibility of the school.

One of the fundamental reasons for the establishment of this new graduate school of nursing lies within the requirements of the State Board of Education. To qualify as a certified teacher of health under this board one must be a graduate of a four year college course comprising an approved course in health. Much of the health instruction heretofore given the pupils in this State has not been by certified teachers of health but by either the regular teachers or the school nurses.

It is true that the University of Connecticut has not secured the approval of the National Organization of Public Health Nurses nor of the League of Nursing Education for its new project. This may come later, especially since the National Organization of Public Health Nurses is not in the habit of accepting any proposed program until it has been in operation for one year. Its own requirements differ enough from those of the State Board of Education so that at present were a nurse to attempt to meet both it would necessitate about one third more time spent in study.

The third step as outlined in this new program calls for concentration in a major field of specialization. Plans for this specialized study are little more than in the formative stage. It is only fair to state that not all the members of the committee working out the tentative program are in agreement. There is every reason to believe, however, that the project will be carried through. At present there is an enrollment of thirty and it is expected that the final enrollment this fall will be at least sixty. Organized medicine hopes that the larger objectives within this program will not be obscured by differing opinions and policies.

Why Exhume the Midwife?

There are two things which the midwife will never be able to carry out and which are essential to modern obstetrical care, (1) a physical examination, and (2) the administration of an anesthetic at

the time of delivery. Why, then, look with longing eyes at the midwifery services of Europe, as has the Editor of the *New England Journal of Medicine* in a recent editorial¹ wherein he offers the midwife in its "new order" as a substitute for the obstetrician during the national emergency produced by World War II? Our neighboring editor reminds us that, although gratifying, the reduction in maternal deaths and morbidity is by no means satisfactory. Yet there has been an extraordinary and almost nationwide drop in maternal mortality during the past few years.²

How can we hope to train "the new order of midwife" in this country without any adequate group of training centers, comparable in any way to the British and Scandinavian schools of midwifery? Neither the Lobenstein School in New York City nor the Frontier Nursing Service of Kentucky could presume to train midwives in either quantity or quality sufficient to supplant the obstetrician in modern maternity work.

The low maternal mortality rates of Leslie County, Kentucky, of the Philadelphia Midwives Service, and of Louisiana with its colored midwives are cited as examples of what midwifery service under competent medical supervision may attain. The statement of a prominent Connecticut obstetrician is very pertinent. "It always provokes me to read 'The Philadelphia Midwives Service shows a mortality rate of half that of the city as a whole.' There is no justification whatsoever for making any comparison between these two rates, they are not talking about the same things. For example, the maternal mortality rate of the city as a whole includes the death from abortions which is about 25% of the total. Now it is well known that a great many of these abortions are started by midwives and of course none of them are chalked up against the midwives in the official figures. The absurdity of making such comparisons is quite apparent. Women who know from the start that they have complications such as heart disease, diabetes, contracted pelvis, previous cesarian section, etc., do not go to the midwives at all. They are automatically eliminated from her whole practice. They go to the doctors, whether it be at home or in the hospital, and the death rate of course is higher. It would be more correct to compare the maternal mortality of the midwives with that of an outpatient obstetrical

1. *N. E. Jour. Med.*, Aug. 21, 1941.

2. *Daily, E. F., Amer. Jour. Ob. & Gyn.*, Aug. 1941.

service where deliveries are effected in the home by students of medicine."³

Connecticut has been able to eliminate the midwives from the entire obstetrical program and this has been welcomed by every physician in the State. It is no argument for more and better midwives because high maternal mortality rates persist due to meddling obstetricians. Let us rather train better obstetricians and not substitute midwives for poor doctors. It is also no argument for an increase in midwives in the North because Louisiana can improve on the poor midwives which prevail in the South and make them less dangerous. The National Emergency is no excuse for bringing back the midwife, even though she be of the "new order." Rather should it stimulate our medical schools and our hospitals to produce more efficient obstetricians, sound of judgment and well grounded in pathology as well as in clinical experience.

O C D — The Latest in Defense Planning

About July 1, 1941, the Hartford County Medical Association published its Plan for Civilian Disaster Preparedness. With the object in view of supplying "immediate and adequate medical, hospital and nursing care to the victims of any disaster with certainty and the least possible confusion," the plan seemed quite simple. It was so arranged that it should operate under the direction of and as an integral part of the plan for Civilian Preparedness of the Connecticut State Police. Each hospital in the county has its function in the operation of the Plan, and the graduate nurses, Visiting nurses and Red Cross all have their duties to carry out.

Early in September 1941 there appeared from the U. S. Office of Civilian Defense at Washington, Medical Division Bulletin No. 1, Emergency Medical Service for Civilian Defense. This plan calls for a Director of Civilian Defense to take command of all local civilian defense forces, including medical. It is more complex than the Hartford County Plan and does not depend so much on police coöperation. In addition to offering a detailed plan for the organization and expansion of hospital facilities along both seaboards and in industrial areas in the interior, it includes plans for the rapid expansion of nursing facilities through intensive training of adequate numbers of Volunteer Nurses' Aides and other nursing auxiliaries.

All this is predicated on the bombing which

civilians may be exposed to in this war. This catastrophe may never reach our shores, and then again, as in the England of 1938, it may be but just around the corner. An official bulletin issued in England that year emphasized the need for emergency medical preparation, just in case. It was only a year later Britain was at war and only two years before the great German bombing of British cities took place. In addition to the work of doctors and nurses in such an emergency service, the public will be expected to take an active part. First Aid courses are being offered to all and intensive practical instruction in hospitals is available to thousands of women who may be willing to share the burden of the simpler forms of nursing care.

The ruthlessness of the dictator makes any steps looking toward better preparedness for defense a necessity. To Doctor George Bachr, Chief Medical Officer of the Office of Civilian Defense, we offer our hearty congratulations. It is a satisfaction, to the physician at least, to know that the Office of Civilian Defense is not just muddling through the present crisis but has set itself the task of planning and developing a civilian defense program with adequate medical provisions for even remote use.

War Medicine, July 1941

No. 4 of the American Medical Association's new publication made its appearance during the closing days of July. This number contains an interesting article by O. H. Perry Pepper, M.D., in which the author prophesies for the new Army a lower death rate record from disease than existed in the Army of twenty years ago. Doctor Pepper's prediction is predicated on a study of the statistics of diseases in the American Army during the last world war and an analysis of present day knowledge of how more effectively to prevent, diagnose and treat these diseases.

Of timely interest is the article on "Treatment of Shock in Wartime" by Henry N. Harkins, M.D. Accompanying this is an excellent bibliography of the more recent work in this field. "Refractory Gonococcus Infections," "Military Field Sanitation," "Medical Aspects of the Selective Service System," "Rapid Identification of Gas Gangrene Anaerobes," and "The Navy and Social Hygiene in National Defense," all appear in this number. Several pages are allotted to "Notes on the Treatment and Control of Certain Tropical Diseases." A single editorial urges the prompt establishment of a

3. Miller, J. R., Hartford—Personal communication.



THE CONNECTICUT MEDICAL EXAMINING BOARD

THOMAS P. MURDOCK

GEORGE M. SMITH

DANIEL C. PATTERSON

CHARLES J. BARTLETT

JOHN C. ROWLEY

The above photograph is probably the first group photograph ever taken of the Connecticut Medical Examining Board. Because of this the Editor felt it should be published to be made a permanent record of the society. The photograph was taken during a recent meeting of the Board just before they began a discussion of the examination of appli-

cants. Connecticut is one of the very few states which permit the state medical society to recommend to the Governor nominees for this Board. Medical men familiar with the work of the Board feel that it is the first line of defense in the protection of the health of all of the people of the state.

central authority for the procurement and assignment of physicians.

Women's Field Army to Have First General Meeting

The Connecticut Division of the Women's Field Army of the American Society for the Control of Cancer which has been organized by the State Medical Society's Tumor Committee will have its first general meeting in the Sterling Law School Auditorium in New Haven at 8:15 P. M. on October 13. Clarence C. Little, sc.d., Secretary of the American Society for the Control of Cancer and President of the Roscoe B. Jackson Memorial Laboratory at Bar Harbor, Maine, will address the meeting on the work of the Field Army. Members of the Society and all other interested persons are invited to attend this meeting. There will be no admission charge.

Doctor Little is a well known personality in the field of cancer control and research. He has conducted cancer studies at the Cold Spring Harbor Laboratory, has been the president of the University of Maine and the University of Michigan from which he resigned to return to his earlier field of cancer study. It was through Doctor Little's efforts that funds were provided for the financing of the Jackson Laboratory at Bar Harbor which has contributed interesting studies in the field of genetics and cancer.

The cancer control program in Connecticut has taken another important forward step with the organization of the Women's Field Army. From the modest start about ten years ago the entire project has been stimulated and guided by the Tumor Committee of the State Society with the coöperation of the State Department of Health.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
258 CHURCH STREET NEW HAVEN

RECORD CONGRESS

Just as this issue of the Journal goes to press Doctor Maurice Strauss, Chairman of the Committee on Registration of the Clinical Congress has announced that there were 751 registrations for the 1941 Congress. This registration surpasses all records, the previous high record was 700 in 1940.

COUNCIL RESUMES MEETINGS
Dates Set for 150th Anniversary Celebration

The Council resumed its monthly meetings on September 17 after the summer recess. All members of the Council were present and important items of business were transacted. Following the executive session of the Council it met with the Planning Committee and sub-committee chairmen on the Sesquicentennial.

Sesquicentennial Celebration
June 3 and 4, 1942

The Council voted that the 150th anniversary meeting of the Society which has long been planned to be held in Middletown in 1942 would be on Wednesday and Thursday, June 3 and 4. The meetings will be at Wesleyan University. The first meeting of the Society was in Middletown on October 9, 1792.

Annual Meeting of House of Delegates
1942

In order to comply with the By-Laws of the Society it is required that the House of Delegates have its annual meeting in May and the Council voted that the annual meeting of 1942 be held in the City of New Haven on May 20. The usual year end meeting of the House of Delegates for the purpose of passing on the Society's budget for next year and such miscellaneous business as is properly brought before the House will be held in New Haven on December 3.

Committee on Prepaid Medical Service

The Council approved the appropriation of \$100 to defray the necessary expenses of the Committee on Prepaid Medical Service. After two years of study and survey and the review of plans and developments in other states this Committee is now

formulating definite proposals that will be presented to the House of Delegates at its annual meeting.

Change in Roster Listings

The Council voted that academic degrees would be eliminated from the membership listings in future annual rosters.

Have You Paid Your Dues?

The Treasurer of the Society has consolidated the reports of dues payments that were filed by the County Secretaries as of September 1. The percentage of members of each of the County Associations that had paid their dues by that date is given below.

Fairfield	71%	New Haven	70%
Hartford	71%	New London	49%
Litchfield	60%	Tolland	85%
Middlesex	63%	Windham	78%

Membership is automatically terminated on December 31 if dues are unpaid.

The Committee on Consulting Staffs to
State Institutions

The Committee studying the appointment and compensation of consulting staffs of State institutions which consists of Doctor Maurice T. Root, Chairman, C. John Satti, John D. Booth met on September 17.

(Concluded on page 777)

THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

Bridgeport Hospital

37 preliminary students entered the Bridgeport Hospital School of Nursing on September 3. This is about a 20% increase over the number accepted last September.

An adequate supply of graduate nurses continues to be a problem, especially with the increased activity in the hospital with its greater demands on nursing service.

The problem of supplementary workers, such as maids and orderlies, is also very great due to the demand for these people in the factories, which are very active in Bridgeport.

Plans are being made for a refresher course, and also for a course in Nurses' Aides, which will be conducted with the coöperation of the American Red Cross. It is hoped in this way that we shall be able to meet our problems better in nursing service.

The hospital was represented at the American Hospital Association Convention at Atlantic City by Oliver H. Bartine, Superintendent, together with several of his departmental heads.

Bristol Hospital

HOSPITAL PLANS DEFENSE COURSE

In view of the overcrowded condition of the Bristol Hospital and the serious shortage of nurses, and also to help in the National Defense Preparedness Program, Bristol Hospital arranged to give a teaching course of six weeks to young girls with high school education. Our course began July 1 with twenty young women.

The purpose of this course is to meet two needs:

(1) To provide supplementary trained help as Auxiliary Nurses to meet the on-coming shortage of nurses who are leaving local institutions to enter military hospitals to serve their country as Army Nurses.

(2) To open a field of activity for young women who are too young or for other reasons are unable to enter registered schools of nursing.

The schedule of the course follows:

Nursing Principles and Methods	-	-	20	hours
Demonstration and Procedure	-	-	20	hours
Personal Hygiene	-	-	20	hours
Bacteriology	-	-	5	hours
First Aid	-	-	5	hours
Care of Equipment	-	-	5	hours
Dietetics	-	-	5	hours
Practical Dietetics	-	-	5	hours
Nursing Ethics	-	-	5	hours
Communicable Diseases	-	-	5	hours

Upon completion of the course, passing of examinations and acceptance of student, applicant receives \$40 per month for the first six months and \$60 thereafter if her services have proven satisfactory. The Hospital did not guarantee employment but selected outstanding students from the classes as needed from time to time.

Requirements on completion of the course were given as follows:

1. Hours of duty: 7:00 A. M. to 3:00 P. M., 3:00 P. M. to 11:00 P. M., and 11:00 P. M. to 7:00 A. M., one day off a week.

2. No maintenance is given except one meal daily, laundering of two uniforms and three aprons weekly.

3. Uniform material is purchased by the Hospital and paid for by the applicant. The uniforms are made by the Hospital.

4. White shoes and white stockings must be worn.

5. Hair nets to be worn at all times while on duty.

The text of the student's agreement is printed below:

"In view of the presentation of this excellent course with its attending costs to the Hospital and with but slight costs to the Student, it is agreed: that I, ..., agree to offer my services to the Bristol Hospital for this auxiliary assistance for a period of six months after completion of this course.

Signed

All applicants were required to fill out blanks

giving the information requested.

Those participating in the course included the Superintendent of the Hospital, the Directress of Nursing, Staff Physicians, and Floor Supervisors. The only paid instructor was Mrs. Howard Wright who gave the Red Cross course supplemented by our physicians.

The fifth and sixth weeks were given over to practical bedside nursing under supervision.

Twelve young women are now employed at the hospital giving very satisfactory service.

Charlotte Hungerford Hospital

The month of August recorded a new high in the daily average, 120, and also in the number of births at the Charlotte Hungerford Hospital, 65 children, including a set of twins, were born.

Tuesday, October 7, has been set as the annual Fall meeting of the Litchfield County Medical Association which according to custom will be held at the summer home of Doctor and Mrs. Harry B. Hanchett at Bantam Lake.

The first meeting of the Charlotte Hungerford Hospital Auxiliary held under the direction of the new officers was held on Tuesday, September 16, in the Auditorium of the hospital. Preceding this meeting the Board of Directors held a short business session. Doctor Albert W. Buck discussed the plans of the Connecticut Hospital Association and of the State Defense Council for the handling of sick and injured under the State Defense Program.

The Annual meeting of the Board of Governors of the Charlotte Hungerford Hospital has been set for October 20 at which time Staff appointments for the coming year will be made and reports from the Heads of Departments, Chiefs of the various services and the Director will be presented.

Danbury Hospital

On the 25th of August, non-professional employees were entertained at a picnic at Lake Candlewood. About forty of the help attended. Games were played and a hot dog roast was enjoyed by all.

On August 26, twenty young women entered the training school to begin a three year course of training. Our Training School graduated fifteen young women on Wednesday, September 10. The speakers at the exercises were Doctor Donald F. Gibson and the Reverend Jack Baker.

The following attended the meeting of the American Hospital Association at Atlantic City: Miss Anna M. Griffin, Superintendent; Mr. F. Ward DeKlyn, General Manager; Mrs. Charles A. Mallory representing the Board of Managers; and Miss Alice Wile.

Greenwich Hospital

After exhaustive study of the various costs of care of patients, it was decided on July 1 to increase the rates of all classes of patients fifty cents per day.

Ten students were graduated this September from our School of Nursing. The incoming class of twenty students is the largest we have had in a number of years.

Fred J. Loase, Administrator, and Edwin F. Saunders, Assistant Purchasing Agent, attended the American Hospital Convention at Atlantic City.

Griffin Hospital, Derby

Our thirty second fiscal year ended May 31, 1941, the busiest year in the history of the hospital.

The hospital days numbered 30,242, with an average of eighty three patients per day. We had 534 babies born. Our daily expense per patient averaged \$5.82.

During the year we were able to make a few improvements: Our two operating rooms were equipped with Castle Lights, and the doctors' scrub room remodelled. Also, we are installing a new autoclave. With a little remodelling of our maternity wing, we now have a new nursery and infants' examining room, and a formula room.

The nursing situation is very acute, as we are finding it difficult to obtain graduate nurses, and we have no training school. We are hoping to augment the present shortage with a subsidiary group to relieve the nursing department of many routine duties.

We are also having great difficulty in obtaining domestic help, this, of course, is on account of the industrial area we are in.

In conformity with the Defense Program, Red Cross classes in First Aid have been given to our Staff Nurses, also, two classes were held for the laity. We expect to carry on more classes in the fall.

Another Gray Lady Unit of the American Red Cross will be started next month. Our first unit of Gray Ladies was started last January, and they have

proved their worth in the aid given to the hospital.

The hospital was represented at the American Hospital Association Convention by Miss Helen T. Nivison, Administrator.

Municipal Hospital, Hartford

The labor situation is average in comparison with other institutions because of the present conditions. There is a shortage of staff nurses here as there is at most hospitals at present.

Our students consist of about 20 affiliates in the Department of Communicable Diseases who will remain here for six weeks.

Miss Mathieson, Director of Social Service, attended the convention at Atlantic City.

Milford Hospital

We have had the same difficulty as we believe all other hospitals are having in obtaining satisfactory and sufficient help, both professional and kitchen.

The salaries of all nurses were raised \$15 per month for day duty and \$20 per month for night duty.

We are still working on plans for our new addition but as yet have not been able to ask for bids.

Miss Edith M. Oddy, Superintendent, attended the convention at Atlantic City.

Meriden Hospital

Doctor Edward R. Smith, former interne, is now associated with his father, Doctor David P. Smith, chief of the surgical division at the Meriden Hospital. Doctor Edward R. Smith is the third of his generation to follow the medical profession. His grandfather, Doctor Edward W. Smith, now deceased, was one of the pioneer physicians and surgeons in the earlier days of the hospital and was chief of the surgical division in his later years.

Doctor Isaac Horowitz, interne for the past eighteen months, has taken up his residence in Meriden and has opened up a practice with office at 9 West Main Street.

A navy regulation sword was presented to Doctor Stanley J. Boguniecki by Doctor I. S. Otis at the annual summer party of the Meriden and Wallingford physicians. Doctor Boguniecki is the first interne from the Meriden Hospital to join the Navy Medical Corps.

Doctor H. DeForest Lockwood, president of the medical board of the Meriden Hospital, has been

appointed to the Meriden Defense Council by Mayor Francis R. Danaher, to represent the Meriden Medical Society.

A class of 23 students entered the School of Nursing on September 2. This is the largest class in recent years.

Miss Nellie K. Ferguson, Superintendent, attended the 9th Institute for Hospital Administrators in Chicago in August and also the American Hospital Association meeting in Atlantic City.

New Britain General Hospital

A SUCCESSFUL FUND RAISING CAMPAIGN

The \$700,000 Building Fund Campaign which the New Britain Hospital had for new buildings was very successful, the total subscriptions being \$712,649. (Our congratulations to New Britain.) The contemplated building will add from 75 to 100 beds, will provide an entirely new surgery floor, reconstruct some of the older buildings and build a new addition to the Nurses Home. Work has been started and it is hoped it will be completed early in 1942.

The labor situation is bad and does not seem to be getting any better. Nurses are very scarce, both for general and private duty. The refresher course was of very considerable help; almost all of those taking it came into the hospital for general duty or took private cases. A number put in their whole time during the summer, others part time only because of home conditions.

The hospital has taken a third more students this year which is all that could be accommodated until the addition to the Nurses Home is completed.

Doctor I. S. Geeter attended the Hospital Convention at Atlantic City.

New Haven Hospital

THE INTEREST IN NURSING GROWS STEADILY

In order to assist in the program of National Defense and to meet its responsibilities in a time of crisis, the nurses of the country have sought to interest an increasing number of highly qualified young women to enter schools of nursing during the coming year.

Connecticut has done its share and it is interesting to note that an increased interest in the profession of nursing has been demonstrated by college women.

During the past year the Yale University School of Nursing has received letters of inquiry concerning nursing from 1,471 students. Of these 585 were from college women.

At this date, 76 students have been accepted for enrollment in the School and will enter on September 16. In addition to this number, 69 college women filed applications. Some of these were declined and others, who were accepted, withdrew their applications largely for two reasons, finances and marriage.

It is worthy of note that the 76 students now enrolled represent 42 different colleges, covering a geographical range from Maine to Texas and from New York to California.

Lawrence and Memorial Associated Hospitals, Inc., New London

Mrs. Ann S. Morgan has been appointed assistant to Richard Hancock, Administrator. Mrs. Morgan attended the Institute for Hospital Administrators in Chicago in August.

The hospital was represented by Mr. Hancock at the American Hospital Association Convention in Atlantic City.

The class of 23 students was admitted two months early, July 15. It is expected to enter an extra class in February 1942.

In line with other hospitals throughout the State, the Lawrence and Memorial Associated Hospitals have worked out a very complete plan for the hospitalization of disaster victims in the case of major or minor catastrophes. A very detailed manual has been compiled and multigraphed and every doctor and employee in the hospital has been supplied with a copy. A skeleton outline is here presented.*

EMERGENCY PROGRAM FOR THE LAWRENCE & MEMORIAL ASSOCIATED HOSPITALS

Commissioner of Police has recommended that all injured persons should be transported directly to the nearest hospital.

Catastrophes shall be divided into two classes—Minor and Major.

MINOR

Hospital office upon receiving call from physician at scene of accident shall:

Make record of all information.

Dispatch ambulance immediately with emergency supplies and crew. (Box with Emergency supplies in Emergency Room No. 2.)

Call and send to accident, following three physicians: (Listed with telephone numbers.)

Notify Chief of Staff.

Notify Hospital Administrator.

Notify 3 members of the Surgical Staff to report at Hospital: (Surgical Staff listed with telephones).

Notify Director of Nursing or her Assistant.

Notify Acting Supervisor of Nursing. (She will notify Captain and Team of Nurses who are on call.)

MAJOR

Should the catastrophe be of a major extent, the following additional or alternate steps are to be taken:

Send second ambulance to scene of accident.

Send hospital truck with load of supplies to scene, a nurse to go with truck. (Boxes of additional supplies will be found marked ready to go out in Emergency Room No. 2.)

Summon all other members of the Staff to Hospital *except* if all available aid is needed at the scene, send all physicians of the District there.

Additional physicians to be called: (Listed with telephone numbers.)

Staff set-up at Hospital for Major catastrophe as follows:

General supervision of all activities, and assigning of patients on admission: (Name of Doctor).

To inspect and readjust dressings in emergency room: (Names of Doctors.)

Operating Room teams (teams to work in either Operating Room or the two Emergency Rooms.)

Team I—2 doctors and 2 nurses listed.

Team II—2 doctors and 2 nurses listed.

Team III—2 doctors and 2 nurses listed.

Ear, Nose and Throat—2 doctors and 2 nurses.

Fracture Room—2 doctors and 2 nurses listed.

General Supervision at Hospital—of Wards—1 doctor and 1 nurse listed.

2 additional anaesthetists listed.

In case the catastrophe calls for all help, the State Police will communicate with the hospitals. For all available aid at the scene of the catastrophe, the hospitals shall communicate with all physicians of their districts and dispatch them to the scene.

If a City Emergency Signal is given, all employees of the Hospital are to report immediately to the Hospital, each to his Department Head, to await further orders.

Doctors and Nurses are requested *NOT* to park at or near any of the Ocean Avenue Entrances to the Hospital.

Business Office will have a list of all patients in the hospital who are sufficiently recovered to be transferred to their homes. List will designate whether they are to go by car or ambulance. These patients may be dismissed without a written order, in case of an emergency disaster. Office nurses will keep this file up to date and take care of dismissing such patients. The *Motor Corps* may be called to assist in dismissing patients by car to their homes.

Hospital office upon receiving notification of a disaster will also call: Anaesthetists, Housekeeper, Pharmacist, x-ray technicians, Dieticians, Engineer, Laboratory technicians—(all listed by name with telephone numbers).

DUTIES OF THE OFFICE GROUP

Cashier and Bookkeeper will be responsible for and take charge of all patients' valuables. All valuables must be taken

*Editor's Note: Hospitals which have not as yet prepared such a manual or have not developed their plan for meeting such emergencies should get in touch with Mr. Hancock and get a copy of this very complete layout.

from patient's clothes while he is still in emergency, probably before patient is undressed. They will place valuables in valuable envelope with patient's name on it.

Record Clerk will get from each injured patient or responsible informant—name, address, nearest telephone, nearest relative, etc.

Secretary and assistant will remain in front lobby to answer inquiries.

School Office Secretary will run errands so as not to tie up the switchboard.

Office Nurses to remain in Business Office supervising activities. Each half hour she is to find out the condition of all casualty patients.

Operators: Main switchboard will be used for incoming calls. One operator will be stationed at the pay station on first floor to take all out-going calls. A nickel will be attached to phone for emergency use. Once a contact is established with the central telephone office, it should be asked to keep the line open for calls.

NURSING DEPARTMENT

Director of Nursing will be in charge.

Minor Catastrophe: Call Captain of team who will call members of her team—report at School Office for further orders.

Major Catastrophe: All nurses off duty will report on duty—to School Office for assignment. All orderlies off duty will report to School Office for assignment.

Detailed instructions for all other departments are given also.

Neuro Psychiatric Institute of the Hartford Retreat

The fourth graduating class of the Neuro Psychiatric Institute's Post Graduate School of Nursing received their diplomas September 15. The 15 women graduates make a total of 55 graduates who have been admitted to the Annie W. Goodrich Alumnae Association, the Post Graduate Nurses Association.

These specially trained graduates have completed the school's 12 month course in psychiatric nursing. In addition to psychiatry, they have studied the history and ethics of psychiatric nursing, care technique and case study method, nutrition, sociology, educational therapeutics, elementary and advanced psychology, psychopathology, neurology, neurological nursing, endocrinology, mental health and child guidance. For admission to the school, students must already be graduates of a Class "A" nursing school and must have completed two or more years of university work.

Doctor Nolan D. C. Lewis, director of the New York State Psychiatric Institute and Hospital, was

the principal speaker. Doctor Lewis, who is a member of the Institute's Board of Nursing Advisers, has for several years been field director of the Scottish Rite Masons' survey for correlating and evaluating research on dementia praecox. He was the Salmon Memorial Lecturer in 1940.

This year's graduating class will join previous graduates throughout the country in administrative and teaching positions in institutes and hospitals, where they will serve as active exponents of the graduate school's system of psychiatric nursing education.

Norwalk General Hospital

As usual the September quarter was a busy one for the Norwalk General Hospital. Customary activities were complicated by problems incidental to National Defense. There was particular difficulty in securing satisfactory male employees and in addition there was a real shortage of graduate nurses. Therefore, the administrative personnel had a keen realization that they were earning their salaries.

Alterations are proceeding on the fourth residence recently purchased, in which twenty or more graduate nurses will be housed. The total cost will be approximately \$16,000. This will enable the Hospital to house forty-five graduate nurses and sixty four students.

On September 2 a class of twenty student nurses was admitted, less than the number anticipated. The hospital with an average of approximately 180 patients daily requires a school of about ninety students. Therefore, thirty to thirty five should be admitted to the school annually. An investigation is now being made concerning the wisdom, and the possibility, of admitting a February class.

The graduation of the 1941 class of nurses took place on Sunday evening, September 14, in the Norwalk High School auditorium. Congressman LeRoy D. Downs delivered an inspiring address to the twenty one graduates.

Miss Marguerite C. Holmes, retiring Superintendent of Nurses, led the graduating class in the Florence Nightingale pledge. Miss Priscilla K. Hall, Principal of the School and Director of Nurses, who took office September 1, presented various scholarships including those awarded annually by Mr. and Mrs. Harold L. Lloyd, Greens Farms, amounting to \$1,200, to be used in postgraduate nursing study.

The hospital this year had the largest representa-

tion in its history at the National Convention. Delegates at the Atlantic City Convention were Mrs. Louis A. Lehmaier, Sr., President of the Woman's Board, Mrs. C. J. Copley, President of the Hospital Volunteers, and Robert N. Brough, Superintendent.

Expenses continue to rise. The total for July was \$38,173, topping the June figure of \$37,086. Both of these were the highest in the history of the organization. The per capita cost for the year ending September 30 will be in the neighborhood of \$6.65, an increase of approximately 35 cents above the 1940 figure. With the Wholesale Commodity Price Indices reaching new peaks, the question arises as to whether or not hospitals should place a surcharge on their bills, representing the percentage of increase since July 1. If slow inflation is to take place, this would be a much easier method of balancing revenue and expense than reprinting price lists each three or four months.

Stamford Hospital

Our men are leaving for industrial situations requiring some mechanical ability. The various industries seem willing to take men on and train them for particular jobs whether they have had previous experience or not.

We are entering today a class of 26 preliminary student nurses. There seems to be a decided shortage in nurses, especially in graduates for special nursing and for floor and supervising duty.

There is as yet no immediate change in financial support; we have not yet raised our rates for either ward or private room service but are considering the advisability of doing this.

The hospital was represented at the convention in Atlantic City by Mr. Charles H. Young, Superintendent.

ONE SQUAB, FIVE OUNCES PROTOPLASM

Dear Doctor:

A great many children come into this world every year with a decided deficiency of the squab elixir in their little bodies, and continue to suffer for the want of the supply of it until some bright physician advises they be given squabs to eat, as it is practically the only known way of supplying this life-giving fluid. It is a well demonstrated fact that nothing is so beneficial in the treatment of children's diseases, such as dyspepsia, stomach and intestinal, where the pancreatic and gastric juices have vanished and the ptyalin of the saliva has disappeared.

This squab elixir is almost instantly absorbed into the

veins and is the most nourishing, invigorating and vitalizing juice the medical profession has ever discovered, especially in the cases before mentioned, and also in all other "wasting away" diseases due to malnutrition. It must be understood that squabs as a life-building food are not necessarily confined to children—far from it. Anyone suffering from dyspepsia, indigestion, chlorosis or any of the system-depleting stomach diseases is equally benefited.

One squab contains two to five ounces of liquor protoplasm. This is the liquor of life, without which nothing can live.

Prescribe squabs for your patients who need them and see the results.

Our squabs are large, juicy, white-meated, raised from our large EXTRA WHITE KING PIGEONS, and trademarked "ROYAL," so you may be sure of the best.

Squabs are also fine eating for those who enjoy the good things in the food line often taking the place of quail or other game which cannot be had.

We raise all we sell and kill and dress only on order. Recipes furnished.

Mrs. Henry M. Gamber, Beech St., Oakland Gardens, Farmington Conn. Tel. 134-14.

FROM THE SECRETARY'S OFFICE

(Continued from page 771)

Committee on Public Relations

The Society's active Committee on Public Relations under the Chairmanship of Harry L. F. Locke met in the office of the Society on September 18.

Tumor Committee

The Tumor Committee under the Chairmanship of Charles L. Larkin had one of its frequent and important meetings on September 17 during the Clinical Congress.

The Committee on Public Health

Joseph H. Howard, Chairman of the Society's Committee on Public Health, has called a meeting of the Committee at the Society's office on October 9. The agenda for the meeting will include discussion of:

1. The role of nutrition in defense.
2. Compulsory vaccination.
3. State-wide pasteurization of milk.
4. Methods of follow-up in cases of syphilis discovered in Selective Service examinations.
5. Case finding program of the State Tuberculosis Commission.

MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic
FRANCIS G. BLAKE, Dean Yale School of Medicine New Haven		STANLEY H. OSBORN, State Commissioner of Health Hartford	
GEORGE M. SMITH, M.D., State Chairman, 258 Church Street, New Haven, Conn.			

MEDICAL PROVISIONS FOR CIVILIAN DEFENSE

The activities of the U. S. Office of Civilian Defense are concerned primarily with the protection of lives and property in the event of enemy action. To this medical division, of which Doctor George Baehr is Chief Medical Officer, is entrusted the responsibility for the preparation of plans for civilian defense designed to prevent or alleviate the medical or public health hazards to which the civilian population may be exposed.

Copies of the medical division Bulletin #1, "Emergency Medical Service for Civilian Defense," have been received from the office of F. H. LaGuardia, U. S. Director of Civilian Defense. This Bulletin is one of a series of recommendations to State and Local Directors of Civilian Defense concerning the organization of medical facilities in their areas. The Bulletin presents a simple basic plan for the organization of Emergency Medical Field Units related to hospitals which can be adapted to the needs of any community. It directs attention to possible future requirements of hospital facilities, both within a community and outside its boundaries. As a basic consideration the Bulletin recommends the immediate preparation of a local inventory, reports of which should be filed with the Area Office of Civilian Defense. In addition it is recommended that steps be initiated in each local area for the rapid expansion of nursing facilities through intensive training of adequate numbers of nursing auxiliaries.

This Bulletin and its recommendations has been distributed to the members of the Society's Committee on Medical Preparedness and was considered by the Committee at its monthly meeting held on September 11th.

Members of the Society Ordered to Active Duty

Sidney Aiken, Manchester
Francis H. Burke, Rockville
Paul P. Duzmati, Bridgeport
George A. Leonard, Waterbury
United States Navy (unofficial information)
William F. Green, Newtown
George C. Wilson, Wallingford

Previous Orders Revoked

Paul P. Duzmati, Bridgeport
Frank Mongillo, New Haven

Changes in Selective Service Organization

Fairfield County Advisory Board
Edward R. Roberts added as otolaryngologist.
New London Advisory Board
Charles M. Krinsky added as psychiatrist.

Board 8-A

Robert H. Jordan, New Haven, added as alternate examiner.

Samuel C. Spinner, New Haven, added as alternate examiner.

Board 23-A

Upton S. Reich, Bridgeport, resigned.

Arthur J. Sekerak, Bridgeport, resigned.

T. Smith McLean, Jr., Bridgeport, added as alternate examiner.

Board 26-B

Robert A. Northrop, Norwalk, added as alternate examiner.

Disqualifications for Physical Defects in the Selective Service

Statistics setting forth the rates for physical disqualification in the Selective Service in Connecticut have recently been made available to the Society by

the headquarters of the State Selective Service. The data available covered the period from the beginning of the operation of the draft in November, 1940, to August 1, 1941. During the period covered 10,334 enrollees were given physical examinations by the medical examiners attached to the Selective Service boards, of this number 9,400 were found qualified for military service and 934 or 27.16% were rejected because of physical defects.

The total number of candidates examined by the sixty five boards showed wide variation. A Hartford board examined the greatest number, 1,001; the smallest number of examinations was by the Groton Board, 174.

Rejections for physical reasons have varied within wide limits. There were two boards that showed minimum physical rejections, in these two localities only 10% of the candidates examined were disqualified. From this low level the rejection rate mounted to 52.4% by the board with the maximum physical rejections. Twenty nine boards have had a rejection rate above the average for the State (27.16%).

Rejections by the Induction Board have been declining steadily and the average Induction Board rejection rate for the nine months covered by the present study has been 8.51%. Here again the experience of the boards lack consistency. The board with the minimum has had 1.1% rejections by the induction line. The highest Induction Board rejection rate is 17.2% and it is of interest to note that the board with this record is also the board mentioned above with the highest rejection rate in the original examination. Thirty seven boards have had an Induction Board rejection rate above the average (8.51%).

Below is given a tabulation of the rejection rate of each of the boards. In the first column they are listed in order of the percentage rejections by the local boards' examination. The second column shows the percentage of rejections by the Induction Board.

	Local Board Rejection	Induction Board Rejection		Local Board Rejection	Induction Board Rejection
1.	10%	3.0%	32.	25.9%	9%
1.	10	9.0	33.	26	16
2.	14.2	13.8	34.	26.3	9
3.	14.9	11.4	35.	28.6	10.4
4.	15	16	36.	29	4.6
5.	15.1	9.6	37.	29.8	5
6.	15.6	4.5	38.	30	9
7.	15.7	10.2	38.	30	3
8.	16.9	12.9	38.	30	1.1
9.	17	11.7	39.	30.2	5.7
10.	17.7	6	40.	31.5	3.1
11.	18.1	8.3	40.	31.5	7.9
12.	18.6	5.7	41.	31.8	10.4
13.	18.7	8	42.	32	9.3
13.	18.7	7.6	43.	32.9	2
14.	19	11.6	44.	33.1	12.8
15.	19.4	12.7	45.	33.2	9.8
16.	19.5	10.3	45.	33.2	8
17.	20	11.1	46.	33.5	10
18.	21.3	5.9	47.	34.3	8
19.	21.6	7.3	48.	34.6	5.1
20.	22.2	10.8	49.	35	9.1
21.	22.4	11.2	50.	36.4	10.3
22.	22.5	6.5	51.	38.2	5
23.	23.1	4.2	52.	39.8	10.6
24.	23.6	15.7	53.	40.5	10
25.	23.8	11.2	54.	40.8	11
26.	24.1	13	55.	43.8	9
27.	24.3	6	56.	45.5	4.7
28.	24.5	9	57.	45.8	8
29.	24.6	8.6	58.	46	3.3
30.	25	8.4	59.	52.4	17.2
31.	25.8	15.3			

Connecticut Red Cross "Behind the Lines"

HARRY T. BREDENBERG

Eastern Connecticut Field Representative
American Red Cross

Behind the frontlines of United States defenses a civilian army of more than 1,000,000 American Red Cross volunteers is swinging into action. Thousands of Connecticut men and women have a regiment all their own in this great battle force, and their primary duties are:

- To provide service and relief for needy families of service men not otherwise provided for.
- To aid service men in their personal problems.

- To maintain Field Directors at military stations and outposts.
- To maintain Social Service and Recreation workers at military hospitals.
- To provide comfort articles for men in military hospitals.
- To collect blood plasma volunteered for the Army and Navy.
- To provide millions of surgical dressings for hospitals.
- To enroll nurses, medical technologists, dietitians for military service.
- To give First Aid and Water Safety instruction to the armed forces.

To train millions of citizens in First Aid and Home Nursing to safeguard life and health of civilian population.

To provide refugee civilians with the necessities of life.

To organize evacuation schemes, first aid detachments, ambulance and emergency hospital service for civilian populations.

To organize Disaster Preparedness to meet sabotage, fires, explosions or armed attacks on civilians.

To organize and equip millions of volunteers in Canteen Service, Motor Corps and comfort production.

And if you don't think that's a big job, then drop around to any one of the 40 Red Cross Chapters in Connecticut some day this week and have a look for yourself.

Figure out Connecticut's share of 5,000 miles of gauze and 1,250,000 pounds of cotton and it will give you an idea as to how many of the 40,000,000 surgical dressings the American Red Cross has just completed for the U. S. Army were made by our women volunteers. Then add to that the Nutmeg State's share of 20,000,000 surgical dressings and 3,846,317 garments which the American Red Cross sent to war stricken populations abroad and the total will give you a real picture of what Connecticut's mothers and daughters, wives and sweethearts have been doing with their spare time since September 1, 1939.

In the fiscal year just closed there were trained in Connecticut 1,215 home nurses, and this instruction is being given to hundreds of other women and girls all the time. Adult holders of Red Cross First Aid certificates during that same period numbered 8,535 and new classes are constantly increasing the total.

In a growing number of Connecticut Chapters volunteer nurse's aides are being trained to assist in hospitals under the supervision of doctors and registered nurses. Some 15 Chapters in the state already have organized Motor Corps and other communities are training volunteers for this important service.

In government hospitals Red Cross Gray Ladies extend their well-known courtesies to patients, and in the Veterans Administration Facilities in Newington and Rocky Hill the Red Cross Motor Corps is playing an important part in transporting patients to and from clinics.

Connecticut Chapters are active in enrolling

medical technologists for the Army and Navy and in the southern part of the state, particularly around Bridgeport, Chapters have been very successful in securing volunteer blood donors for the blood plasma reservoir which the Red Cross is building for the Army and Navy.

Chapter Home Service Committees throughout the state are working hand in hand with Red Cross field directors in army camps and naval stations, aiding men in service and their families with personal problems. This same service is afforded ex-service men and their families.

Local Red Cross Disaster Preparedness Committees are perfecting community organization to meet all emergencies. Their activities are tied in closely with state and local civilian defense committees. Also, the State Defense Council in Hartford, has asked that air raid wardens and other civilian defense workers in local communities be trained by the Red Cross in First Aid, Water Safety, Accident Prevention and Home Nursing.

Connecticut is definitely Red Cross conscious. For many years it has been one of the leaders in all Red Cross activities, and in this present national emergency the Connecticut regiment of Red Cross volunteers is really proving its mettle.

Red Cross Blood Collections On Nation-Wide Basis

At the request of the Surgeons General of the Army and Navy, the American Red Cross will extend its blood collection program to key metropolitan cities on the Pacific coast and in the midwest. This was announced at National headquarters by James L. Fieser, vice chairman in charge of Red Cross domestic operations, who said negotiations were now under way with large chapters, which because of the geographical location, size and facilities, were equipped to be included in the program.

At present seven eastern cities are engaged in the project. Collections are shipped by refrigerated express to a processing depot at Philadelphia where blood is reduced to dry plasma form for use by the Army and Navy. Arrangements are being worked out with biological laboratories in the midwest and Pacific areas for processing blood collections received from the cities to be added.

Plans for extending the collection program were announced following completion of a "pilot"

(Concluded on page 788)



PUBLIC AFFAIRS

HEALTH PROGRAM OF NATIONAL YOUTH ADMINISTRATION

The health program of the NYA has been viewed with interest by many and with suspicion by some. A number of inquiries have been received from physicians in the State as to what it was all about and officials of several state medical societies have asked what Connecticut was doing about it. In order that everyone might know, PUBLIC AFFAIRS asked Doctor Clement Batelli, State Health Director of the NYA to prepare a resume of the Program. Doctor Batelli is Director of the Bureau of Tuberculosis in the Department of Health of the City of New Haven.

NYA Health Program in Connecticut

CLEMENT F. BATELLI, M.D.
State Health Director for NYA

The National Youth Administration, when it was organized in 1935, was essentially a relief agency, and youths qualified for NYA only if they belonged to relief families. However, as economic conditions improved and the depression receded, the primary objective of the NYA changed from one of giving relief to providing young people with basic work experience in order to fit them for jobs in private industry.

Industry has long recognized the need for healthy employees, and many employers now require rigid pre-employment examinations. If industry needs and wants employees who are physically fit, it would be a waste of time, effort and money to train youths for skilled work without making sure of their physical fitness. A youth, trained in the manual skills and of strong body, is an asset to his family, community and nation.

The Health Program of the NYA was initiated to complete the job of preparing the youth for employment. The objectives of the Health Program are:

- (1) A thorough physical examination of every youth assigned to an NYA job.
- (2) Correction of health defects through the utilization of existing local agencies or private physicians and dentists,—developing in the youth an interest in his own personal health.

(3) Advice and assistance in all NYA activities related to the health of the worker, with special emphasis on nutrition, sanitation, physical development and recreation.

In carrying out the above mentioned objectives in Connecticut, it was decided to divide the State into four areas, and each area into two examining centers. The location of the examining centers depended, to a large extent, on the facilities available and the coöperation of the agencies doing health work in each area. Accordingly, eight examining clinics were set up; four hospital clinics located at Waterbury, Stamford, Willimantic and Norwich, two Welfare Clinics (Bridgeport and New Britain), one Health Department (Hartford), and one at the NYA headquarters in New Haven.

Each clinic is staffed with two physicians (male and female), dentist, nurse and other necessary professional and technical personnel required to carry on a good health program. In addition, specialists in nutrition, dental hygiene, recreation and safety are available from the staff office.

The aid of local medical societies, health officers and hospital authorities was solicited, in order to obtain well-qualified physicians and nurses to staff the various clinics. Their advice and assistance has been most welcome, and because of this method of selecting personnel, the clinic staffs are on a par with the best in the State.

A thorough physical examination is given every youth assigned to an NYA job. This examination is comprehensive in nature and includes the eyes, ears,

nose, throat, teeth, chest, abdomen and heart. In addition, small-pox vaccinating, Wassermann testing, tuberculin testing and x-raying of positive reactors, and urinalyses are also made. The results of the examination are recorded on standard forms and discussed with the youth in subsequent visits.

The Health Program is under the direction of the State Health Administrative Officer. He is assisted by the State Health Director, (physician, part time), whose primary functions are to give professional and technical supervision and guidance to the Health Program throughout the State. In addition, there is an Advisory Committee made up of members representing public health, medical and dental societies and industry.

One of the most difficult problems connected with the NYA health services is the organization of a good follow-up system and the correction of defects found. From the very beginning, the NYA health authorities have pointed out that this program was not one of medical care, this being the responsibility of the family and community. This policy has been enforced here in Connecticut. Youths are examined and advised regarding the results of the examination, but *Not Treated*. All NYA youths requiring this follow-up service are referred to their own private physicians or dentists or to existing local agencies. However, as a large number of NYA youths are not in a position to afford private services, it necessarily follows, that, after proper investigation, local Welfare Agencies must be called upon to help out.

The success of the NYA Health Program in the State of Connecticut is due in large measure to the wholehearted coöperation and help of the several agencies doing health work in the various communities. Local Medical and Dental Associations, Public Health Officers, Hospital and Clinics, Tuberculosis Leagues, the Visiting Nurse and Welfare Associations, have all contributed in making this program what it is today—medically sound.

A School of Nursing at the University of Connecticut

STATE UNIVERSITY ESTABLISHES GRADUATE SCHOOL OF NURSING

S. WILLARD PRICE, *Director of University Extension*

For the past several years requests have come to the University administration from the nursing profession and the medical profession for an in-service

training program leading to the bachelor's degree for nurses. This program should be a continuation of the work done in the nursing schools conducted by the hospitals of the state. In a discussion of the problem involved, it was generally agreed that the first contribution which the University should make would be in the form of a program for nurses in service who have completed the program of the hospital nursing schools, leading to the bachelor's degree. During the past year a committee composed of representatives from the nursing profession, the medical profession, and the education profession, worked upon a tentative program. The following persons participated:

Hartford Hospital School of Nursing: Miss Rachel McConnell, Director.

Hartford Board of Education: Doctor Charles C. Wilson, Director of Physical and Health Education; Miss Marion V. McCarthy.

Hartford Medical Society: Doctor Albert R. Keith, President.

Middlesex Hospital School of Nursing: Miss Delia H. Newton, Director.

Mt. Sinai Hospital: Mrs. M. E. Kelly, Acting Superintendent.

Municipal Hospital: Miss Mary E. Sullivan, Institutional Supervisor.

St. Francis Hospital School of Nursing: Sister M. Mechtilde, Director; Sister M. Annunciata, Associate.

State Board of Examiners for Nursing: Miss Agnes K. Ohlson, Secretary.

State Department of Education: Doctor Charles J. Prohaska, Supervisor of Health Education.

State Department of Health: Miss Hazel V. Dudley, Director of Bureau of Public Health Nursing.

University of Connecticut: S. Willard Price, Director of University Extension; J. Frank Daly, Supervisor University Extension Center.

Visiting Nurse Association: Miss Marion H. Douglas, Executive Director; Miss Mabel E. Grover, Educational Director.

Norwich State Hospital: Doctor Florian Heiser, Consulting Psychologist; Miss Elizabeth Bixler, Director of Nursing.

The School of Nursing is organized primarily to meet the needs of hospitals, schools of nursing, public health agencies, social service organizations, public schools and industries, for personnel trained and

educated beyond the present schools of nursing. The establishment of the School obviates the necessity, on the part of these institutions, of seeking personnel from outside the state of Connecticut.

The School will offer a curriculum leading to the degree of Bachelor of Science, and is open to all who have been graduated from a school of nursing recognized by the Connecticut State Board of Examiners for Nursing. Before a student is admitted as a candidate for the degree the general entrance requirements of the University shall be met, as regards high school record, scholastic aptitude and moral character. In addition to meeting this requirement, each candidate for a degree must submit to the Director of Student Personnel a copy of his or her scholastic record in the school of nursing, that it may be evaluated in terms of semester-hours of college credit.

The degree of Bachelor of Science is awarded by vote of the board of Trustees to students who have met the following requirements: (1) Earned a minimum of 120 academic credits, at least 30 of which must have been earned at the University of Connecticut; (2) met all the requirements of the school of nursing, and been recommended by its faculty; (3) taken a general examination in their major and closely related work.

The fee of the School of Nursing is \$7.50 per semester-hour and must be paid twice a year, in advance, at the beginning of each semester. A deposit of \$10 is required of all who enroll for the degree. This is later refunded, less any charges outstanding. Each entering student is asked to contribute \$2 toward a volunteer scholarship fund created to render financial aid to students in the School of Nursing.

The program contemplates that the first step in matriculation is the evaluation of the student's transcripts, both from high school and nursing school. College credit will be given for work done in nursing schools. This credit will vary in amount, depending upon the quality and quantity of work done in each individual case. The second step in the program will consist of meeting certain degree requirements which are imposed upon all students receiving a university degree.

The third step is concentration in a major field of specialization. This part of the course has yet to be worked out. Committees have been formed to work during the ensuing year upon requirements within each major. These committees will be composed of

persons from the nursing, medical, and education professions, and will report in the spring of 1942.

In setting up the program the committee members have kept in mind not only the requirements of the National Organization of Public Health Nurses and the various certifying agencies within the state, such as the certification department of the State Department of Education, but also have reviewed very carefully the programs offered in all of the leading universities. The committee members feel that they have worked out a program that will compare favorably with any now in existence, both as to quality and quantity of work required.

Consideration was given to a five year program of nursing that would be done in coöperation with some of our leading hospitals. The committee and the University administration felt that this should probably come as a second step in the development of the School of Nursing. The committee members, without exception, were agreed that the basic problem, the most pressing problem at this time, was the one centering in the in-service training of those who are already in the profession. Ample evidence is available to show that the nurses in our state are not only ready but anxious to have a degree program available.

Since it is absolutely essential that a School of Nursing have a very intimate working relationship with hospitals, it is logical that such a program should be developed as a part of the work within the Division of University Extension and should be developed in our major centers. The program as proposed will go into operation primarily in Hartford in an extension center which has been equipped and staffed for such a program, and in a limited degree in Norwich, in connection with the State Hospital there. It should be re-emphasized that all standards governing and credit granted in this program are comparable to campus standards and credit.

For any further details on the proposed program, those interested should write to the Division of University Extension, University of Connecticut, Storrs, Connecticut, or to Mr. J. Frank Daly at the University Extension Center, 354 Bellevue Street, Hartford, Connecticut.

President Establishes New Health Bureau

MR. McNUTT HAS NEW TITLE

The President of the United States has created the Office of Health Defense and Welfare Services in the Office for Emergency Management, and named

Paul V. McNutt Federal Security Administrator, Director.

The chief effect of the creation of this new bureau is to change the title and position of Mr. McNutt in the defense structure. Previously he has been head of the Office for Coördination of Health, Welfare and Related Services in the Council of National Defense. Mr. McNutt is quoted as saying that the action amounted to "putting more teeth" in the Health, Welfare, Educational, Nutritional and Recreational Activities. The section of the proclamation directs the new unit "to coöperate and work in conjunction with the Office of Civilian Defense in its relationships with state and local groups," but it is made clear that the organization would not replace that of the Office of Civilian Defense in Health and Welfare Matters. It is further pointed out that the Security Administration had broad duties under the defense structure a long time ago before the Office of Civilian Defense was created, and that while the new office will have charge of all Federal Assistance in connection with defense and its effects on civilian population, the Office of Civilian Defense will continue to develop its own voluntary health and welfare organization.

The chief duties of Mr. McNutt's new agency are outlined in the proclamation:

Subject to such policies, regulations and directions as the President may from time to time prescribe the office shall:

"A. Serve as the center for the coördination of health and welfare services made available by the departments and agencies of the Federal Government, and other agencies, public and private, to meet the needs of State and local communities arising from the defense program, and take necessary steps to secure the coöperation of the appropriate Federal departments and agencies relative thereto.

"B. Make available to States and localities, upon request, the services of specialists in health and welfare activities to assist in the planning and execution of such local and State programs.

"C. Study, plan and encourage measures designed to assure the provision of adequate defense health and welfare services to the citizens of the nation during the period of the emergency, and coördinate studies and surveys made by Federal departments and agencies with respect to these fields.

"D. Keep the President informed with respect to progress made in carrying out this order and per-

form such related duties as the President may from time to time assign or delegate to it."

The Georgia Medical Association Plans Care for Rural Communities

The Georgia plan has been proposed by the doctors of Georgia and although the plan has not yet been presented to the legislature it has attracted rather wide medical interest and discussion in the South. In presenting this plan the doctors made it clear that this plan is not advocated as a cure-all for all the ailments of southern medicine or southern rural medicine, but it is merely an attempt to fill the need for more doctors in rural areas.

The core of the plan is to be the two Georgia medical schools. Each year a list would be compiled of the rural communities which are in need of doctors and the communities on this list would be offered as a place of practice to young doctors just out of school, or preferably to those having one year of internship. The local or state government would furnish the applicants an office, a laboratory, and an automobile, and would guarantee them a certain minimum annual income. These "rural internships" would be under the supervision of the medical schools or of a specified nearby physician with a well established practice. The graduates would accept these positions for a period of two years and at the end of that time they may stay on if they desire under the same arrangement, go elsewhere to practice, or return to a hospital as assistant resident physicians.

The advantages to the graduate are many but the two most important are that he would have a fixed income for a set period and would receive invaluable experience in this field work. The advantages to the medical profession and state are: (1) it would supply a sufficient number of rural doctors; (2) it does not involve the medical profession in the undesirable regimentation of state medicine; (3) and it would not be a difficult financial enterprise for the government, as in many cases part or all of the guaranteed income would be met by the communities themselves.

It was thought that the chief objection to this plan might be the small number of medical students who would volunteer. However, the contrary was found true. A large number of seniors when approached on the subject, indicated they would be glad to undertake two years of rural practice under this plan.

SPECIAL NOTICES

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

Date: Thursday, October 23, 4:00 P. M., at St. Francis Hospital, Hartford.

Subject: Some Aspects of Carcinoma at St. Francis—A non-statistical discussion.

Presentation:

1. Carcinoma of Uterus Andrew F. Resnisky, M.D.
2. Carcinoma of Breast Christopher J. McCormack, M.D.
3. Carcinoma of Lip Richard E. Dunne, M.D.
4. Carcinoma of Bladder Dillon D. Reidy, M.D.
5. Accessory Diagnostic Procedures Edward J. Whalen, M.D.

6. Palliative Surgery Richard C. Buckley, M.D.

General Discussion.

Buffet Supper, following the meeting.

All licensed physicians are urged to attend these meetings but if they plan to stay for supper please drop a line to that effect to Doctor Louis P. Hastings, St. Francis Hospital, or to Doctor C. L. Larkin, 101 No. Main St., Waterbury, Conn.

ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY MEETS IN CHICAGO OCTOBER 19-23, 1941

The forty sixth annual meeting of the American Academy of Ophthalmology and Otolaryngology will be held at the Palmer House, Chicago, October 19-23, under the presidency of Doctor Frank R. Spencer, Boulder, Colo.

The academy's program consists of one general scientific meeting on the morning of the first day, separate programs for the two specialties on alternate afternoons and instructional courses every morning beginning on Tuesday.

The feature of this year's general opening meeting will be a symposium on vertigo, with Doctor Francis H. Adler, Philadelphia, representing ophthalmology; Doctor William J. McNally, Montreal, otolaryngology, and Doctor Bernard Alpers, Philadelphia, neurology. Among papers to be presented during the remainder of the week will be the following:

Doctor Alfred W. Adson, Rochester, Minn., Surgical Treatment of Vascular Diseases of the Orbit.

Doctor Albert N. LeMoine, Kansas City, Mo., Allergy and Ophthalmology.

Doctors John H. Dunnington and Maynard Wheeler, New York, Operative Results in 200 Cases of Convergent Strabismus.

Doctor W. F. Petersen, Chicago, Otolaryngological Problems and the Weather.

Doctor Mark J. Schoenberg, New York, The Problem of Preventing Partial or Total Loss of Vision in Glaucoma Patients of Eye Clinics.

Doctor Charles T. Porter, Boston, Practical Uses of Chemotherapy in Ear, Nose and Throat Work.

Doctor Rea E. Ashley, San Francisco, The Use of Urea in Certain Diseases of the Ears, Nose and Throat.

Doctor Alfred J. Cone, St. Louis, Treatment of Sinus Diseases in Children.

Doctor Frederick T. Hill, Waterville, Maine, What Otolaryngologists Can Do For Defective Hearing.

During the convention there will be various meetings of small groups, including the "Teachers' Section," secretaries of local eye, ear, nose and throat societies and alumni organizations. The meeting of the teachers' section will be concerned especially with the role of the Academy in national defense during the present emergency. There will also be a scientific exhibit that will include such subjects as "Ocular Conditions in Children Due to Systemic Disease," "Conduction of Sound in the Ear," "Hemophilia and Other Blood Dyscrasias as Manifest in the Eye, Ear, Nose and Throat," "Cancer of the Larynx" and "Significance of the Eyegrounds in the Problem of Hypertension."

Alternating with the scientific programs of the specialties each afternoon will be an elaborate motion picture program. Thus when the section of ophthalmology is meeting for formal presentation of papers, motion pictures on otolaryngology will be available for those interested in that field.

Doctor Perry Goldsmith, professor of otolaryngology in the University of Toronto Faculty of Medicine, Toronto, Ont., will be the academy's guest of honor this year.

Officers of the academy in addition to Doctor Spencer are Doctors Ralph Irving Lloyd, Brooklyn, president-elect; Everett L. Goar, Houston, Texas, James M. Robb, Detroit, and Ralph O. Rychener, Memphis, Tenn., vice presidents; and Secord H. Large, Cleveland, comptroller. Doctor William P. Wherry, Omaha, Neb., is executive secretary-treasurer.

NEW ENGLAND POSTGRADUATE ASSEMBLY

Sponsored by the Massachusetts, New Hampshire and Rhode Island Medical Societies, the Maine Medical Association and the Vermont and Connecticut State Medical Societies

October 29-30

Sanders Theatre, Harvard University,
Cambridge, Massachusetts

The Fourth Annual Assembly, sponsored by the above societies, is fortunate in having the following speakers:

Doctor Frank E. Adair New York City
Associate professor of surgery, Cornell University Medical College; and attending surgeon and executive officer, Memorial Hospital, New York City.

Doctor J. Burns Amberson, Jr. New York City
Professor of medicine, Columbia University College of Physicians and Surgeons, and visiting physician-in-charge, Tuberculosis Service, Bellevue Hospital.

Mr. J. J. Bloomfield Bethesda, Maryland
Chief, States' Relations Section, Division of Industrial

Hygiene, National Institute of Health, United States Public Health Service.

Doctor William Darrach New York City
Professor of clinical surgery, Columbia University College of Physicians and Surgeons, and attending surgeon, Presbyterian Hospital, Fracture Service.

Doctor John F. Fulton New Haven, Connecticut
Sterling Professor of Physiology, Yale University School of Medicine.

Doctor John S. Lockwood Philadelphia
Associate in surgery, University of Pennsylvania School of Medicine, and assistant surgeon to the Hospital of the University of Pennsylvania and the Pennsylvania Hospital.

Doctor H. M. Marvin New Haven, Connecticut
Associate clinical professor of medicine, Yale University School of Medicine, and attending physician, New Haven Hospital.

Doctor William S. McCann Rochester, New York
Charles A. Dewey Professor of Medicine, University of Rochester School of Medicine and Dentistry, and physician-in-chief, Strong Memorial Hospital and Rochester Municipal Hospital.

Doctor Damon B. Pfeiffer Philadelphia
Director, Pfeiffer Surgical Clinic, Abington Memorial Hospital, surgeon-in-chief, Lankenau Hospital, and associate professor of surgery, Graduate School of Medicine, University of Pennsylvania.

Doctor Homer F. Swift New York City
Member, Rockefeller Institute for Medical Research.

Doctor George W. Thorn Baltimore
Associate professor of medicine, Johns Hopkins University School of Medicine, and associate physician, Johns Hopkins Hospital.

Doctor Norris W. Vaux Philadelphia
Professor of obstetrics, Jefferson Medical College of Philadelphia, and obstetrician and gynecologist-in-chief, Philadelphia Lying-in, Woman's Building of Pennsylvania Hospital.

You are cordially invited to attend; the registration fee is three dollars. The complete program will be mailed to every registered physician in New England. If you do not receive an application blank, please notify the Secretary, Postgraduate Assembly Committee, 8 Fenway, Boston. Registration credentials will be mailed on receipt of three dollars with the application.

DOCTOR REGINALD FITZ, Chairman

DOCTOR LEROY E. PARKINS, Secretary

Postgraduate Assembly Executive Committee.

Program

Wednesday, October 29

MORNING SESSION

Presiding chairman: Doctor George L. Schadt

Associate chairman: Doctor Emery M. Porter

9:50 Assembly called to order by Doctor Reginald Fitz, chairman, Postgraduate Assembly Executive Committee.

10:00 "Pathology of Rheumatic Fever." Doctor Homer F. Swift.

10:30 "The Anemias of Pregnancy: Their classification and treatment." Doctor Norris W. Vaux.

Intermission

11:15 "Preclinical Tuberculosis in Young People." Doctor J. Burns Amberson, Jr.

11:45 "Chemotherapy in Surgical Practice." Doctor John S. Lockwood.

12:15 Luncheon (Memorial Hall). Presiding chairman: Doctor Benjamin F. Cook, Secretary of the Vermont State Medical Society.

1:15 Address by Mr. J. J. Bloomfield. Subject: "The Private Physician's Opportunity in Industrial Medicine."

AFTERNOON SESSION

Presiding chairman: Doctor John F. Gile

Associate chairman: Doctor Halbert G. Stetson

2:00 "The Use and Abuse of the Electrocardiogram in Clinical Medicine." Doctor H. M. Marvin.

2:30 "Treatment of Tuberculosis: The selection and adaptation of modern procedures." Doctor J. Burns Amberson, Jr.

3:00 "Fluid Balance. The Miller-Abbott Tube." Doctor Damon B. Pfeiffer.

Intermission

3:45 "Sulfanilamide in the Prevention and Treatment of Peritonitis." Doctor John S. Lockwood.

4:15 "Diagnosis and Treatment of Tumors of the Breast. Male and female." Doctor Frank E. Adair.

4:45 "The Renal Lesions in Hypertension." Doctor William S. McCann.

7:00 Dinner (Memorial Hall). Presiding chairman: Doctor Frank R. Ober, president of the Massachusetts Medical Society. Toastmaster: Doctor David Cheever. Speaker: Doctor John F. Fulton. Subject: "Bombs."

Thursday, October 30

MORNING SESSION

Presiding chairman: Doctor Charles E. Mongan

Associate chairman: Doctor Frederick R. Carter

9:00 "Treatment of Addison's Disease: Adrenal insufficiency and the use of synthetic adrenocortical hormone." Doctor George W. Thorn.

9:30 "Fractures of the Lower End of the Radius." Doctor William Darrach.

10:00 "Visible Manifestations of Rheumatic Fever." Doctor Homer F. Swift.

10:30 "Chemotherapy in Bacteremia and Meningitis." Doctor John S. Lockwood.

Intermission

11:15 "Treatment of Burns." Doctor Damon B. Pfeiffer.

11:45 "The Diagnosis of Coronary Artery Disease." Doctor H. M. Marvin.

12:15 Luncheon (Memorial Hall).

- 1:15 Question Period. Presiding chairman: Doctor P. L. B. Ebbett, president of the Maine Medical Association. Questions presented by Doctor Albert A. Hornor.

AFTERNOON SESSION

Presiding chairman: Doctor Charles G. Mixer

Associate chairman: Doctor Soma Weiss

- 2:15 "The Problems of Glomerulonephritis." Doctor William S. McCann.

- 2:45 "A Study of the Mechanism of Edema Associated with Menstruation. The Role of Gonadal and Adrenocortical Hormones in the Production of Edema." Doctor George W. Thorn.

- 3:15 "Fractures Around the Ankle Joint." Doctor William Darrach.

Intermission

- 4:00 "The Effectiveness of Blood Transfusion and the Injection of Blood Substitutes in the Acute Hemorrhages and Anemias in Pregnancy." Doctor Norris W. Vaux.

- 4:30 "Metastatic Cancer." Doctor Frank E. Adair.

MILITARY SURGEONS MEETING

OCTOBER 29—NOVEMBER 1

Brown Hotel, Louisville, Ky.

Among the many medical meetings of this year, one of the most timely and interesting is that of The Association of Military Surgeons of the United States to be held October 29-November 1 at the Brown Hotel, Louisville, Ky.

All members of the medical profession are invited to attend as guests and it is particularly hoped that as many members of the Medical Defense Committees as possible will come.

War medicine and surgery has changed considerably since the previous emergency. Mechanization of armies and air bombardments have created new and difficult problems in traumatic surgery and methods of treatments of wounds and extreme abrasions.

For every member of the profession who can be present at this meeting there will be something of special interest.

The session concludes with a mass review of Military Medicine and an inspection of Fort Knox.

Through the Chairman of the Program Committee for the Louisville meeting, Major General Charles R. Reynolds, it is possible to give a preliminary tentative program of professional sessions of that meeting. Arrangement of a schedule of papers has not yet been made. The following is a tentative list of the speakers of the meeting, with titles as far as they have been announced:

Colonel Harold D. Corbusier, Medical Reserve, U. S. Army, "Presidential Address."

Rear Admiral Ross T. McIntire, Surgeon General of the Navy, "Policies and Activities of the Medical Department of the United States Navy in the Present National Emergency."

Doctor Warren F. Draper, Assistant to the Surgeon General, U. S. Public Health Service, "Present Policies and Activities of the United States Public Health Service."

Brigadier General Frank T. Hines, Administrator of Veterans' Affairs, "Progress of the Part the Veterans' Administration is Playing in the National Defense Program."

Major Frank B. Wakeman, Medical Corps, U. S. Army,

representing Major General James C. Magee, Surgeon General, U. S. Army, "Present Policies and Activities of the Medical Department of the United States Army."

Colonel Robert H. Duenner, Medical Corps, U. S. Army, Fort Knox, Ky., "Medical Service of the Mechanized Forces."

Colonel Paul E. Howe, Sanitary Corps, U. S. Army, "Nutritional Problems of the Army."

Colonel Fred H. Albee, Medical Reserve, U. S. Army, "Treatment of Ununited Fractures of Importance to the Military Service."

Captain Lucius W. Johnson, Medical Corps, U. S. Navy, "Medical Service at Remote Naval Bases."

Captain William L. Mann, Jr., Medical Corps, U. S. Navy, "Medical Arrangements for Combined Operations of Land Forces and Sea Forces" (with motion pictures).

The following are scheduled for papers, the titles of which are not yet available:

Major General C. R. Reynolds, U. S. Army Ret., Brigadier General Leigh C. Fairbank, Assistant to The Surgeon General, U. S. Army, Colonel Irvin Abell, of Louisville, Ky., Colonel Leonard C. Rowntree, Medical Reserve, U. S. Army, Chief, Medical Division, Selective Service System, Washington, D. C., Colonel Raymond A. Kelsner, Veterinary Corps, U. S. Army, Lieut. Colonel David N. W. Grant, Medical Corps, U. S. Army, Office of the Chief of the Air Corps.

CONFERENCE ON INDUSTRIAL HEALTH

Under the auspices of the American Association of Industrial Physicians and Surgeons the American Conference on Industrial Health will hold its Second Annual Meeting on November 5 and 6, 1941, at Chicago Towers, Chicago, Illinois. This organization maintains a public forum for all who are interested in the prevention of disease, injury and disability in industry, and the active supervision and promotion of health in industrial groups.

The opening session will be a symposium on the technical problems of industrial health on the basis that health supervision in industry involves two great principles: (1) the adjustment of the working environment to the employee; and (2) the adjustment of the employee to the working environment, including also the human environment. The technical problems are the result of the application of these principles, and run the whole gamut of public health as applied to industry.

The afternoon session will be a symposium on the economics of industrial health, including: (1) organization and cost of a health service, and (2) discussion on the value of industrial health service to the employer, the employee and the public.

The morning of the second day will be given over to a symposium on the social implications of industrial health, discussing how far an industrial health service should go; are hospital and medical care plans related to industrial health service in any practical way; does legislation play a part in this problem; and the evaluation of labor turnover, spoilage, and lack of trained men, together with the experiences of management and the interests of insurance carriers in the medical and social problems presented.

The sessions will close with a schedule of plant medical department inspections, by special arrangements with local industries.

THE FOURTH ANNUAL FORUM ON ALLERGY
 Detroit, Michigan
 January 10th and 11th, 1942

DIRECTORY OF MEDICAL SPECIALISTS

The second edition of the Directory of Medical Specialists is now being prepared and will be ready for distribution next February. The new directory will carry biographical, geographic and alphabetical listings of all diplomates who have been certified to January 1, 1942, by the 15 American Boards which conduct examinations in medical specialties.

Local specialists who are eligible for listing in this forthcoming directory are urged to return the questionnaires which have been forwarded by the publication office. Failure to do so may result in omission of your name. There is no charge for these listings.

The directory will be published every two years by the Advisory Board for Medical Specialties.

ANNOUNCEMENT OF VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held at Atlanta, Georgia, June 1, 2, and 3, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten, double spaced copy sent to the Corresponding Secretary, Doctor T. C. Davison, 478 Peachtree Street, Atlanta, Georgia, not later than April 1.

The Committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays. Doctor Asher Chapman of Rochester, Minnesota, received the Award for the year 1941 in recognition of his essay entitled "The Relationship of the Thyroid and the Pituitary Glands to Iodine Metabolism and Extrathyroid Iodine Metabolism."

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any journal selected by the author.

Prevalence of Encephalitis in the United States

A serious outbreak of encephalitis has been reported in some of the West North Central States

since the first of July. On July 14, Dr. Maysil M. Williams, State Health Officer of North Dakota, reported the occurrence of 25 cases in that State from July 1 to 12. Ten cases had been reported in the State during the first half of the year. Up to August 9, a total of 363 cases, with 41 deaths, had been reported in North Dakota.

Recent reports show an increasing number of cases of the disease in both South Dakota and Minnesota. In the latter State a high incidence has been reported in the western area adjacent to North Dakota.

MEDICAL PREPAREDNESS

(Continued from page 780)

project in which blood donors of the seven eastern cities filled an initial request of the Navy for 15,000 donations. It was explained that most of these, after being processed and hermetically sealed, already have been placed aboard U. S. fighting ships engaged in the Atlantic sea patrol.

"The present emergency requires that the Red Cross take every necessary step to provide as soon as possible an adequate supply of plasma for the Army and Navy," Mr. Fieser said. "Some 200,000 donors will be needed to fill current requests of our military and naval forces. Extension of the collection program will enable the Red Cross to meet these requests.

"Those who have given their blood can have the satisfaction of knowing that it is today on the high seas safeguarding the lives of our sailors. Donations in increasing numbers not only will enable the Red Cross to complete its purpose of supplying adequate supplies to our naval vessels, but also will make it possible to furnish medical units of the Army the amounts requested."

The first step in widening the blood collection program will be to set up collection depots at Los Angeles, San Francisco, Chicago, Detroit, St. Louis, Cleveland, Indianapolis, Cincinnati and Pittsburgh. Those cities now engaged in the program include New York, Boston, Philadelphia, Baltimore, District of Columbia, Buffalo and Rochester (N. Y.). As the program gains momentum, other cities will be added. Biological laboratories undertaking the processing of the blood have agreed to do so on a non-profit basis.

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THE FORUM

Putting one little word after another (with apologies to Joe Williams) and whatever became of the pituitary extract that would positively grow hair on a bald head? . . . The whole vitamin and endocrine setup smacks of high pressure salesmanship. Claims and counter claims flood the literature; we wonder where the gold lies. . . . Mont Reid calls the American appendicitis mortality rate a "national disgrace"; Alvarez decries the number of normal appendices removed without adequate cause; caution dictates to the surgeon "that it is better to be safe than sorry"; the three should get together, they may find the magic key. . . . Adults do get careless and children will swallow poisons. A little card listing the active ingredients and antidotes of the more common trouble makers should be part of the emergency kit. It is also wise to keep a jar of the so called universal antidote in the kit. It comes in handy when the poison is unknown. Components: pulverized charcoal—2 parts, tannic acid—1 part, magnesium oxide—1 part. Dose: 2 teaspoons and repeated as necessary. . . . Why wait until an epidemic scare prods your patient to seek smallpox vaccination. A note on his history sheet plus an occasional verbal reminder is good preventive medicine and slack period business. . . . Now comes a sulfadiazine emulsion for the treatment of burns. It forms a transparent, germicidal seal over the burned area. Advantages claimed: it does all that other measures do, plus the added value of visual control of the area; because of its intrinsic germicidal powers, infection is minimal and the result is lessened scarring. Time will tell. . . . Did you know that even though you are a registered M.D., you cannot buy or give a certain rabies and distemper vaccine to your own dog? The manufacturer requires that each package must be signed for and given by a registered veterinarian. . . . Reliable reports insist that strontium bromide intravenously

gives prompt and prolonged relief in acute attacks of bronchial asthma. . . . In the rush of new things, it is possible to lose track of some valuable old remedies. Potassium iodide in small doses takes no back seat to the endocrines in the treatment of functional menstrual disorders in the adolescent girl. It is especially valuable in their dysmenorrheas. And don't forget that it is still an old standby for the geriatric trade. Ammonium chloride is another old timer in the spotlight. Someone recently discovered that alone, or as an adjunct to endocrine therapy, it has no equal for the relief of premenstrual and menopausal jitters. . . . Thiamine chloride therapy to the contrary, the one best bet in the treatment of acute alcoholism and delirium tremens is the intravenous injection of 10% solutions of glucose plus suitable amounts of insulin. This treatment has also demonstrated its value in the acute toxic liver conditions. . . . Cancer experts insist that a great majority of lower bowel malignancies are within reach of the examining finger. Their plea is for more and better rectal examinations. . . . Research pathologists are still looking for a diagnostic pass-word in blood, urine and feces. They are convinced that alterations in the character of these media will eventually give up definite clues to body dysfunctions. . . . Pieric acid stains on the fingers can be removed by painting them with collodion. Peeling off the collodion takes the stain with it. Gentian violet stains can be removed with alcohol. Boraxo cleans the inside of those little porcelain sterilizers in jig time. . . . Did you know that a Chicago catering house, serving desk lunches to busy business men, always includes a comprehensive vitamin capsule, while an enterprising New York restaurant serves a digestive pill following a complete dinner? . . . Several reports have come in of successful results in gout and arthritis treated with a crude liver extract. . . . Scheduled for early marketing is a protein that may be given intravenously. It will have its chief value as a food for the very sick patient.

T. P. R., M.D.

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Course In Traumatic Surgery

The course in traumatic surgery arranged by the Clinical Congress Committee is the Society's major effort in the field of post graduate education for the coming winter. Instruction commenced during the Clinical Congress, and nearly one hundred physicians have registered.

The course is under the direction of Samuel C. Harvey, William H. Carmalt Professor of Surgery at the Yale School of Medicine, and Surgeon in Chief to the New Haven Hospital.

Associated with Doctor Harvey will be:

Bert G. Anderson, D.D.S., Associate Professor of Surgery.

Alexander L. Bassin, Assistant Professor of Orthopedic Surgery.

Eugene M. Blake, Clinical Professor of Ophthalmology.

Norton Canfield, Associate Professor of Otolaryngology.

Louie N. Claiborn, Assistant Clinical Professor of Surgery.

Clyde L. Deming, Clinical Professor of Urology.

William J. German, Associate Professor of Surgery.

Gustave E. Lindskog, Assistant Professor of Surgery.

Charles C. Lund, Assistant Professor of Surgery in the Medical School of Harvard University.

Max Taffel, Clinical Instructor in Surgery.

Kenneth W. Thompson, Assistant Professor of Surgery.

Paul W. Vestal, Assistant Clinical Professor of Surgery.

Sessions will be held each week until June, 1942, in accordance with the following schedule:

4:30 P. M.

I. September 16 Dr. Harvey

Introductory to the "Course on Traumatic Surgery"

The occurrence and types of injury of particular interest to the surgeon in civil and military activities. A general presentation of the field to be covered.

II. September 17 Dr. Harvey

The General Reaction to Injury and Particularly Peripheral Circulatory Failure (Shock)

III. September 18 Dr. Lund

Abdominal Injuries

The types and occurrence of injuries to the abdomen and its viscera and their diagnosis and treatment.

IV. September 23 Dr. Harvey

The Local Reaction to Injury

The processes involved in the healing of wounds and the restoration of function.

V. September 30 Dr. Harvey

Complications in the Healing of Wounds

The effects of necrotic or foreign materials, and methods of removal.

VI. October 7 Dr. Harvey

Complications in the Healing of Wounds

Infection by pyogenic (aerobic) organisms and prevention, diagnosis and treatment of such infections.

VII. October 14 Dr. Harvey

Complications in the Healing of Wounds

Infection by anaerobic organisms and the prevention, diagnosis and treatment of such infections.

VIII. October 21 Dr. German

Injuries of the Nervous System—Craniocerebral

IX. October 28 Dr. German

Injuries of the Nervous System—Spinal

X. November 4 Dr. German

Injuries of the Nervous System—Peripheral Nerves

XI. November 11 Dr. Blake

Injuries of the Eye

XII. November 18 Dr. Anderson

Injuries of the Jaws and Teeth

XIII. November 25 Dr. Canfield

Maxillo-Facial Injuries

XIV. December 2 Dr. Lindskog

Injuries of the Thorax—Chest Wall, Pleura and Lungs

XV. December 9 Dr. Lindskog

Injuries of the Thorax—Heart, Blood Vessels and Oesophagus

XVI. December 16 Dr. Harvey

Injuries of the Abdomen—Abdominal Wall, Liver and Spleen

XVII. January 6 Dr. Harvey

Injuries of the Abdomen—Gastro-Intestinal Tract

XVIII. January 13 Dr. Deming

Injuries of the Kidneys and Ureters

XIX. January 20 Dr. Deming

Injuries of the Bladder, Urethra and Genitalia

XX. January 27 Dr. Harvey

Injuries of Muscle, Fascia and Tendon

XXI. February 3 Dr. Harvey

Injuries of Peripheral Vessels

XXII. February 10 Dr. Bassin

Injuries of Bone

General principles of diagnosis and treatment, emergency and definitive.

- XXIII. February 17 Dr. Bassin
Injuries of Bone—Compound Fractures
- XXIV. February 24 Dr. Bassin
Injuries of Bone—The Spine and Pelvis
- XXV. March 3 Dr. Bassin
Injuries of Bone—The Shoulder Girdle
and Humerus
- XXVI. March 10 Dr. Bassin
Injuries of Bone—The Lower Arm and Hand
- XXVII. March 31 Dr. Bassin
Injuries of Bone—The Femur
- XXVIII. April 7 Dr. Bassin
Injuries of Bone—The Lower Leg and Foot
- XXIX. April 14 Dr. Bassin
Injuries of Bone—Joints and Bursae
- XXX. April 21 Dr. Vestal
Injuries of the Hand
- XXXI. April 28 Dr. Taffel
Wounds Caused by Crushing Injuries and
High-Explosive Blasts
- XXXII. May 5 Dr. Claiborn
Burns
- XXXIII. May 12 Dr. Claiborn
Plastic Repair
- XXXIV. May 19 Dr. Thompson
Amputations
- XXXV. May 26 Dr. Vestal
Organization of First-Aid Posts
- XXXVI. June 2 Dr. Harvey
Organization of the Hospital for Emergency
Care of Injuries
- XXXVII. June 9 Dr. Harvey
Review of Recent Advances in
Respect to Injuries

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OUR NEIGHBORS

New Hampshire

At the annual meeting of the New Hampshire Medical Society held in Manchester in May 1941 the Committee on Medical Economics submitted a report which contained an interesting recommendation as to group sickness insurance. This committee has considered the advisability of a fact finding survey of conditions in New Hampshire in so far as they apply to the costs of medical care and concluded that it was useless in a time of such rapidly changing economic conditions. The committee recognized that there will come a time when group sickness insurance will be in demand and against this time it believes that the New Hampshire Medical Society should be prepared to introduce such a program if and when it seems advisable. The recommendation was submitted that the Committee on Public Relations or the Committee on Medical Economics consult the Society's attorney for the purpose of drawing up such a bill to be submitted to the legislature at a future time.

The New Hampshire Farm Bureau Federation submitted to the New Hampshire Medical Society a letter which dealt with the formation of a coöperative to underwrite the costs of medical care to low income groups in rural areas. The lack of accurate facts showing the need for such a plan was recognized by the Society and it was therefore referred to the Committee on Medical Economics for a thorough investigation.

The Committee on Maternity and Infancy report 24 maternal deaths in 1940, a rate of 2.8 per 1000 live births, and 274 infant deaths under one year of age, a rate of 32 per 1000 live births. The maternal mortality rate has steadily declined from 6.1 in 1935; the infant mortality rate has dropped from 54 in the same period. Eclampsia leads all other causes of maternal deaths. In 1940 only three fatal cesarean sections were performed, in contrast to five recorded for 1939.

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NEWS

from County Associations

Fairfield

The Fairfield County Medical Association will hold its semi annual meeting on Wednesday, October 1, at the Woodway Country Club, Springdale. A business meeting will be held in the afternoon. After dinner Doctor Eugene deForest Swan of Brooklyn will discuss "The Emotional Problems of Children."

The Fairfield County Medical Golf Association brought its first season to a close on September 24 with a match at the Brooklawn Country Club, Bridgeport. A total of five meets during the summer has offered opportunity for members to test their prowess on various courses in the county. There has been an average attendance of about thirty five. Credit for arrangements goes to Doctors Staub and Yeager, president and secretary, respectively, of the Association.

On Sunday, August 24, the Stamford Medical Society had its annual summer outing. Fifty six members were present to consume two whole sheep, one suckling pig, clams, lobsters, etc. For the first time, this year's soft-ball game was enjoyed without producing any fractured bones.

Stamford was host to Fairfield County Medical Association's golf club on August 27 at Woodway Country Club. About thirty doctors played golf with Doctor Oliver L. Stringfield showing the best card, a 79.

Doctor Charles W. Knapp has resigned the position of chief of staff at the Greenwich Hospital after many years of service, and Doctor John A. McCreery has been appointed to fill the vacancy.

The death of Isaiah Francis Carroll occurred in Stamford on August 28, 1941. Doctor Carroll had practiced in Stamford for over thirty years; he was 66 years old at the time of his death.

The Cornerstone of the new St. Joseph's Hospital in Stamford was laid on September 7. The impressive ceremonies in connection with the dedication were led by Governor Robert A. Hurley and the Most Rev. Maurice F. McAuliffe, bishop of Hartford.

The first fall meeting of the Bridgeport Medical Association will be held at 8:30 P. M. on the first Tuesday in October. Doctor Walter Hedrick of New York Hospital will speak on "Certain Cardiac

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Disorders and Their Treatment."

Doctor Louis Costaldo has been transferred from Fort Wright to Jacksonville. Doctor Goodrich is in the medical service at Fort Devens.

The Kentucky Medical Journal, August 1941, carries an obituary on Virgil P. Gibney by Doctor D. C. Patterson of Bridgeport. Doctor Gibney was Surgeon in Chief of the Hospital for the Ruptured and Crippled in New York City from 1887 until 1924. He maintained a summer home in Bridgeport and we are told "he was cheerfully and charitably at the call of any doctor needing assistance, and applying a body cast in a third floor tenement room on a hot summer day never ruffled his genial disposition."

Hartford

The semi annual meeting of the Hartford County Medical Association will be held on October 28, at the Chippabee Country Club in Bristol. The speakers will be announced in the near future.

The Society mourns the death of its oldest member, Gideon Segur. He reached his 90th birthday on August 22, 1941, and his death occurred on August 31. He became a member of the County Medical Association in April 1887.

Both the medical profession and the city of Hartford will be honored on October 20, 1941, when Frank H. Lahey, President of the American Medical Association and director of the Lahey Clinic in Boston, will speak in Bushnell Memorial. This is a meeting under the joint auspices of the Hartford county and Hartford city medical societies and is for the medical profession and laity alike. Doctor Lahey's subject will be "Developments in Medicine: Economic and Scientific." Because of the prominence of the speaker and his ability to convey his ideas, there undoubtedly will be a large crowd to

hear him. Preceding the meeting there will be a dinner in Doctor Lahey's honor at the Hartford Club.

Doctor Llewellyn Hall, Assistant Medical Director of the Phoenix Mutual Life Insurance Company, is the author of an article entitled "How Much is a Health Examination Worth," appearing in *Proceedings of the Life Extension Examiners*, May-June, 1941. Doctor Hall's article discusses the feasibility of having ten life insurance companies provide health examinations for 10,000 policy holders in an effort to reduce mortality rates and thus contribute to the health of the nation.

The New England Journal of Medicine, July 24, 1941, contains an article by Doctor W. Beecher Scoville and collaborators on the Arnold-Chiari Malformation. At the time this article was written Doctor Scoville was a Resident in Surgery at the Massachusetts General Hospital.

Windham

About a year ago Mrs. Mary L. Mason, widow of Doctor Louis I. Mason of Willimantic, bequeathed practically her entire estate of approximately \$250,000 to the Windham Community Memorial Hospital in Willimantic for the erection and endowment of a Nurses' Home. The building has recently been started, and it may be completed within the next few months. The building was designed by Mr. James L. Mills of New York, and when completed will represent the most modern ideas regarding the ideal Nurses' Home.

The new wing at the Day-Kimball Hospital is nearly completed and probably will begin to function within the next two or three months. The wing adds considerably to the bed capacity of the Day-Kimball Hospital, and also contains complete new operating rooms, as well as a laboratory department.

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QUARTO NOTES

ORBITAL TUMORS. Results Following the Transcranial Operative Attack. By *Walter E. Dandy, M.D.*, Adjunct Professor, Neurological Surgery, Johns Hopkins University. *New York: Oskar Piest.* 1941. 168 pp. \$5.00.

Reviewed by **WILLIAM J. GERMAN**

This monograph is based upon the author's experiences with thirtyone operative cases of orbital tumors. Simple anterior orbital tumors were excluded from the series. The operative approach was through the cranium, with removal of the orbital roof. The fact that 80 per cent of the tumors involved the cranial cavity is sufficient justification for this transcranial operative attack. The more common pathological tumor types were: meningioma with hyperostosis, Schüller-Christian's disease and glioma. The operative mortality was very satisfactory in the author's hands.

The book should be of even greater interest to the ophthalmologist than to the neurosurgeon. The hazard of approaching these extensive intracranio-orbital tumors through the anterior orbit is well demonstrated. It is unfortunate that certain editorial errors appear, but these are of a minor nature.

INFANTILE PARALYSIS. By *Philip Lewin, M.D., F.A.C.S.*, Associate Professor of Bone and Joint Surgery, Northwestern University Medical School, Professor of Orthopedic Surgery, Cook County Graduate School of Medicine. *Philadelphia: W. B. Saunders Company.* 1941. 372 pp. 165 illustrations by Harold Laufman, M.D. \$6.00.

Reviewed by **MAURICE M. PIKE**

This book by Doctor Lewin of Chicago has an excellent preface and introduction and the first fifteen chapters are of particular interest to the general practitioner and pediatrician as well as to the orthopedist. The subsequent chapters deal more intimately with specific orthopedic procedures appropriate in particular cases afflicted with this disease. It is of interest to note that the disease is confined in only about four fifths of its incidence to infants and young children. A great deal of experimental work in various laboratories has been carried out over a period of years and is still going on. It has been found that monkeys cannot contract the disease from each other or from human beings by direct contact. The virus is very resistant to cold and recent investigation has brought sewage into the foreground as a very important factor in the etiological concepts. Adult human beings may be carriers and it is felt the disease may be transmitted through the skin, although the intestinal tract and nasopharynx still are believed to be the most common modes of entry. The manner of spread, transmission and route of infection are still subject to speculation and research. From thirty to sixty per cent of the victims become permanent cripples. It is noted that in temperate climates such as ours most cases occur in July, August and September, whereas in warmer climates this disease is more endemic in nature, not having any seasonal peak. There is no racial immunity

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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but one attack does give immunity. No age group is exempt.

Examination of an acute case must be extremely gentle. Doctor Lewin feels that the use of convalescent serum is impractical both from cost and from its lack of success in the past. It is believed that there are various strains of the virus which attack the motor cells of the spinal cord most commonly and rarely go to the brain. The mode of exit of the virus from an infected patient is felt to be by means of the gastrointestinal tract, from the nose and from the blood, as by an insect bite. Vaccines and serum treatment seem to be of little value at this time in building up any immunity or increasing the patient's resistance.

Poliomyelitis seems to be definitely on the increase. It is of interest to note that in the years 1919 to 1934 there were more cases in the United States and Canada than in all Europe, Australia and New Zealand. Every known country has reported cases but the large epidemics have chiefly occurred in countries with colder climates. The incubation period is supposed to be from one to three weeks. Doctor Lewin believes that there is an inheritance of susceptibility and that fatigue is important. After entering the body the virus has a peculiar affinity for the motor nerve cells of the spinal cord where perivascular infiltration occurs and there is also considerable reaction of the reticuloendothelial system. There seems to be a definite barrier between the blood and spinal fluid. The symptoms of an acute case of poliomyelitis are those of headache, stiff neck or back, tremor, gastrointestinal upset. Superficial reflexes are the first to change. Paralysis if it occurs, and it does not always occur,

appears usually on the second or third day of the disease. Paralysis is apt to begin in the legs and work up. With regard to prognosis and mortality, the higher the lesion the less favorable the prognosis for life but the more favorable for recovery from the paralysis. Twenty five per cent of the cases in an epidemic recover completely. Serum is not effective after the paralysis occurs. Twenty per cent of the cases which develop paralysis succumb. The more technical chapters are of primary interest to the orthopedist and are not summarized here. An excellent bibliography is presented.

High Cost of Making a Doctor

The research committee of the American Medical Association discovered that the cost per credit hour for a medical student was \$26.96 compared to the next highest, \$15.87 for dentistry. The cost for law courses averaged \$11.05, for teaching only \$4.06.

Embryo doctors must have expensive equipment with which to practice. They must have the real thing. They can't play with theory. The average cost of education borne by the student himself is calculated at 55.3 per cent of the total. The rest is taken care of by endowments, payments for services, scholarships, and gifts.

Journal of the Florida Medical Ass'n.

Table of Contents : November 1941

CHEMOTHERAPY IN PELVIC INFLAMMATORY DISEASE

William E. Studdiford, M.D., New York 799

FUNCTION OF THE BILE WITH SPECIAL REFERENCE TO THERAPEUTIC USE OF BILE SALTS

Carl H. Greene, M.D., New York 804

BELLADONNA ROOT TREATMENT OF CHRONIC ENCEPHALITIS

Louis H. Gold, M.D., Hartford 811

PROGRESS REPORT ON EXPERIMENT IN CONTROL OF CANCER OF UTERUS

Catherine Macfarlane, M.D., Philadelphia 814

PHYSICAL STATUS OF AMERICAN YOUNG MEN G. St. J. Perrott, Washington, D. C. 817

CARCINOMA OF THE DUODENUM Norman L. Cressy, M.D., Meriden 818

BACKGROUND OF PUBLIC HEALTH IN CONNECTICUT Ira V. Hiscock, New Haven 821

EDITORIAL

The Small Dust of the Balance	834	New Zealand Experiment	836
The Patient's Dilemma	834	Frank Burr Mallory	837
Socialized Osteopathy	835	A Tout Seigneur Tout Honneur	837
17th Clinical Congress Excels	836		

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	838	THE FORUM	857
CONNECTICUT HOSPITAL ASSOCIATION	841	NEWS FROM COUNTY ASSOCIATIONS	857
MEDICAL PREPAREDNESS	846	NEWS FROM YALE UNIVERSITY SCHOOL	
PUBLIC AFFAIRS	850	OF MEDICINE	859
INDUSTRIAL HEALTH	853	NEW BOOKS IN REVIEW	864

MISCELLANEOUS

OFFICERS AND COMMITTEE CHAIRMEN		OBITUARY	860
Connecticut State Medical Society	4	CONNECTICUT CLINICAL CONGRESS 1941	861
Connecticut Hospital Association	4	PRINCIPLES AND RECOMMENDATIONS OF	
SPECIAL NOTICES	856	JOINT CONFERENCE COMMITTEE	862



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The CONNECTICUT STATE MEDICAL JOURNAL

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NOVEMBER, 1941

No. 11

CHEMOTHERAPY IN PELVIC INFLAMMATORY DISEASE

WILLIAM E. STUDDIFORD, M.D., *New York*

The Author. M.D. *New York University, 1922.*
Director of Obstetrics and Gynecology, Bellevue;
Professor of Obstetrics and Gynecology New York
University, Consultant of Obstetrics and Gynecology,
Greenwich Hospital, Conn., and St. Joseph
Hospital, Far Rockaway, New York

THE REPORT of Colebrook and Kenny¹ in 1936 on the treatment of puerperal infections in humans and experimental infections in mice with prontosil awakened an intense interest throughout the medical world. While one must not forget the earlier studies,^{2,3} this report probably will stand as a landmark in the treatment of infectious diseases. During the past five years a multitude of investigators, using the same or related drugs, have explored the pharmacological, experimental and clinical qualities of those preparations in almost every known infectious process. This group of drugs has proven of unquestionable value in infections caused by the Group A hemolytic streptococcus, the pneumococcus, the meningococcus and the gonococcus. They have proved to be effective in colon bacillus infections of the urinary tract. Staphylococcus infections have been less favorably affected. Infections caused by other organisms, notably the anaerobic streptococcus, have not shown any marked benefit from treatment with the sulfonamides.

In many diseases caused by the former group of organisms we have possessed no specific therapeutic agent up to the present era. In the field of obstetrics and gynecology, these new drugs have been applied chiefly in the two forms of infection most frequently encountered in the pelvic organs, the pyogenic infections occurring mainly after abortion or full term delivery and in the gonorrheal infections.

Before considering the use of those drugs in the pyogenic infections, a few fundamental facts must be emphasized. Puerperal and post-abortion infections are of common occurrence and show a strong tendency to spontaneous cure. The mortality from such infections is low, as can be seen from a consideration of the following figures. An average of over 400 abortions of various types are admitted to the Gynecological Service at Bellevue Hospital every year. Approximately one-third of these patients exhibit signs of infection. Clinically, ninety per cent of this group appear to be localized uterine infections with incomplete abortions. Cultural studies in this group show very few instances of an infection which would be favorably affected by chemotherapy. Except where such infections are present, these cases have been treated by evacuation of placental debris. Excellent results have been obtained.⁴ Three deaths have occurred since January, 1939, one in a patient with a uterine perforation and an intestinal injury, two in patients with general peritonitis caused by a mixed group of organisms. These conditions were present in all three patients before admission. We estimate the mortality at about three per thousand in this period. The cases selected for chemotherapy will be discussed later. Obstetrical morbidity is usually estimated by the application of a febrile standard to a large group of patients. On the Obstetrical Service at Bellevue Hospital the standard used may be defined as a fever of 100.4° or more, on two occasions at least 24 hours apart during the puerperium excluding the first day postpartum. Among a group of 11,400 postpartum patients, 10.5% were found to have a fever of this degree, amount to 1,180 patients. When the standard was raised to 101° F. only 5% of the patients could be counted as morbid. The vast majority had fever of slight degree and

Presented at 149th Annual Meeting, Connecticut State Medical Society, Bridgeport, May 20-22, 1941

short duration. Even among those patients with high fever, only a minority gave any clinical evidence of extension of the infective process past the uterus. This agrees with the findings of Rivett⁵ who, in reporting a group of 533 severe postpartum infections, found that 57% appeared to be local and confined to the uterus. Among the 1,180 patients with postpartum fever 17 deaths occurred due to infection; a mortality rate in this group of 1.5%. Of the 17 deaths, five occurred after Cesarean Section. If one considers only the septic deaths following vaginal delivery the mortality rate drops to 1%. To briefly consider the twelve deaths occurring after vaginal delivery, one was due to a primary pneumococcus uterine infection with septicemia and meningitis; one to staphylococcus aureus septicemia, the focus being at the site of a transfusion; two were cases of hemolytic streptococcus septicemia with general peritonitis; three were cases of anaerobic streptococcus septicemia; three cases showed suppurative thrombophlebitis but the anaerobic streptococcus could not be demonstrated in the blood stream although it is strongly suspected as a causative agent. Autopsies were not obtained on the two remaining cases and the organism responsible for the condition could not be determined. Parenthetically, it may be stated that sulfanilamide was only used in one of the fatal cases, most of them having occurred prior to 1936. Had the sulfonamides been available they might have proved of value only in the first four cases. There is no evidence that they are of value in anaerobic streptococcus infections.

Stress must also be laid on the comparative rarity with which organisms which might be influenced by the sulfonamide group are encountered in puerperal and postabortal infections. Since 1933 2,600 lochial cultures have been taken from morbid postpartum patients at Bellevue Hospital. Sixty-nine of these cultures or 2.7% have shown hemolytic streptococcus. In only 50% have these organisms been predominant. On the Gynecological Service 622 consecutive cervical cultures were taken from cases of abortion complicated by fever. Eighteen of these or 2.9% showed hemolytic streptococci. These organisms were not grouped.⁶ Many of these patients showed no clinical evidence of the presence of a virulent organism, having no fever, or fever of slight degree and short duration. We feel justified in assuming that some of these organisms did not belong to Group A, and that the incidence of such organisms must fall below 1%. Watson⁷ states that

only one severe Group A infection has been seen at Sloane Hospital since 1936, while Douglass states that only 1% of the morbid patients at the New York Lying-In Hospital showed Beta hemolytic streptococci. The hemolytic streptococcus is probably responsible for the epidemic form of puerperal fever and for many of our rapidly fatal, though isolated cases of puerperal and postabortal sepsis. Aside from the hemolytic streptococcus, the other organisms amenable to chemotherapy are rarely found. No case of pneumococcus or staphylococcus infection has been observed at Bellevue since the advent of chemotherapy.

The fact that puerperal and postabortal infections are frequent, are usually of slight degree and of short duration, and that they are usually caused by organisms of low virulence easily overcome by the natural mechanism of immunity, seems quite apparent from these figures. The tendency of the majority of patients to recover spontaneously has been the basis for the apparently successful results of many of the agents formerly utilized in the treatment of large groups of these cases. All of them have eventually been discarded as useless. The speaker believes that the routine use of the sulfonamides on all cases of postabortal and puerperal fever without regard for the nature of the infecting organism will eventually be discarded for the same reason. The drugs may do harm, and if there is no reason to believe that they will do positive good, they should not be used.

The selection of cases for treatment should be made on the basis of lochial or cervical cultures as well as blood cultures in the more seriously sick. Cultures from the cervix and lochia on a blood agar plate, if promptly incubated, should bring positive results, if hemolytic streptococcus is present within from 12 to 18 hours. When Group A is the infecting organism almost a pure culture will be found. These cases show remarkable results with chemotherapy, the use of which becomes more urgent in the severe spreading infections. The results of such treatment, which will be summarized leave no element of doubt as to the value of such drugs when this organism is the causative agent.

Group A hemolytic streptococcus infections in the puerperal or postabortal state may be grouped according to their clinical severity into the following types (a) local uterine infections with slight febrile reaction, (b) local uterine infections with severe febrile reaction sometimes characterized by pelvic parametritis, (c) spreading uterine infections

with severe febrile reaction and the development of peritonitis or septicemia or both. Most patients in group (a) will recover with no specific treatment. However, the administration of sulfanilamide will quickly get rid of the organisms in the uterine discharges if retained secundines are not present; if present these organisms may reappear when treatment is stopped. It is advantageous to get rid of an organism which is a potential danger to the patient and to others in her environment. Cases falling into group (b) and (c) should be actively treated with the drug. Most of the cases formerly fatal were found in group (c) and some were in group (b). Since 1936 we have observed at Bellevue Hospital 13 severe infections in these last two groups. Eleven patients were suffering from early abortion, only two infections following full term delivery. Five belong in group (b), while eight were in group (c). The five patients in group (b) recovered promptly, the organisms usually disappearing from the lochia within a week. Six of the eight patients in group (c) recovered. At autopsy one of the fatal cases showed bacterial endocarditis while the other showed suppurative thrombophlebitis of the ovarian veins. The mortality in this last group was 25%. On searching our records from 1933 to 1936 we found twelve such cases who had not received sulfanilamide. Among them were 10 deaths, a mortality of 83⅓%. There can be no question as to the benefit of the drug in this group of infections.

The drug used in all these cases was sulfanilamide. In spite of the advent of newer and less toxic preparations,¹⁰ it is still thought to be the most effective agent against the hemolytic streptococcus.

The dosage varied but as our experience grew and as we became acquainted with Marshall's¹¹ pharmacological research, we used larger doses given at 4 hour intervals day and night. In severe local infections 8 grams a day are given for 48 hours, the dosage then being dropped to 4-5 grams a day. In spreading infections 12 grams a day are given for 48 hours, the dosage then being dropped to 8 grams a day for 48 hours and finally to 4-5 grams a day. Equal amounts of bicarbonate of soda are given to prevent the occurrence of acidosis. Fluids are moderately limited. When unable to administer the drug by mouth, equal amounts are given intramuscularly, but the oral route is resumed as soon as possible. Estimation of the blood level of the drug has not been carried out routinely. In one case the use of this procedure was decidedly of questionable value.

Termination of treatment is a difficult matter to decide. Some observers depend on a certain number of days of normal temperature.¹⁰ We believe that this criterion in many instances results in unnecessary prolongation of treatment with consequent danger of toxic reactions. By the use of frequent cervical and blood cultures we have found that in most instances the blood and lochia become organism-free in about a week. After a second negative culture, treatment is stopped. This finding is contrary to the observations of Colebrook and Purdie,¹² who found that they were unable to get rid of the lochial organisms. When treatment is continued after the cultures have become negative, occasionally drug fever may appear. Three instances occurred in this series.

Moderate mild reactions were noted frequently such as cyanosis, mild delirium and nausea. These soon disappeared when treatment was stopped. Anemias rapidly developed in most of these patients and were combatted with transfusion. The white cells were counted frequently and in only one instance was a leukopenia noted. This is a small series and as it grows larger it is likely that severe reactions will be encountered due to individual idiosyncrasy. In treating an infection with such a serious outlook, we must be prepared to take this risk.

We have learned to avoid the parenteral route of treatment, if possible, when septicemia is present since abscesses may develop at the site of injection. These require incision and drainage.

We have found that retained secundines may be removed by surgical means with relative safety after sulfanilamide therapy has been in force for 48 hours.

We have seen no patient who developed septicemia, peritonitis or pelvic cellulitis, once treatment has been instituted. In patients in whom cellulitis has been noted before the administration of the drug, rapid disappearance of exudate has followed treatment. These observations, together with the probability that the establishment of endocarditis and thrombophlebitis can be prevented, make it imperative to begin intensive treatment of these infections at the earliest possible moment.

This briefly summarizes our experience at Bellevue Hospital with this form of puerperal and post-abortion infection. As has been stated we have, as yet, had no experience with infections caused by the staphylococcus and the pneumococcus. We believe that sulfathiazole would be the drug of choice in both instances.

The use of the sulfonamides in the treatment of acute gonorrheal infections probably represents one of the most successful applications of this group of drugs. The problem in this type of infection is more clear cut than in the pyogenic group since we are dealing with a disease caused by a single group of organisms. The infection spreads along the surface of delicate mucous membranes and while congestion, oedema and sub-epithelial leucocytic infiltration are present there is little destructive change in the acute disease of the lower genital tract and in the early stages of the initial acute salpingitis. In the later stages of salpingitis with the formation of large accumulations of purulent exudate within thick-walled occluded tubes, the lesion develops into a type not likely to be influenced by chemotherapy, as has been pointed out by Lockwood.¹³

The treatment of acute gonorrhea in the female with the sulfonamides can only be carried out adequately when a bacteriological diagnosis is made before the institution of therapy and when the patient can be shown to be free from organisms during the follow-up. While carefully taken urethral and cervical spreads are fairly accurate during the acute stage, cultural methods have been demonstrated by Carpenter,¹⁴ Douglas¹⁵ and others to be more efficient. In making a bacteriological diagnosis in chronic cases and in the follow-up of treated cases, these newer cultural methods are said to be almost twice as efficient. The improvement of cultural methods will soon cause the smear to be discarded in well-regulated institutions, except as a rapid method of diagnosis. It is to be regretted that cultural methods have not been used in most of the cases of gonorrheal infection treated on the Gynecological Service at Bellevue Hospital. This omission somewhat invalidates the results which are to be reported. We believe, however, that cervical and urethral smears and cultures should be taken for at least three months, preferably following the menses, before pronouncing a patient cured.

Gurnee and Walker¹⁶ in 1937-1938 studied the effect of sulfanilamide on 154 patients. 108 of them were admitted with salpingitis and showed positive spreads; 19 had salpingitis, negative spreads but showed positive complement fixation tests; 21 were patients without salpingitis showing acute urethritis, or cervicitis, or both; three of these patients were pregnant; six had gonorrheal arthritis.

The dosage employed varied, the first half of the series receiving 17 grams during a period of seven

days; 4 grams the first day; 3 grams the second and 2 grams for the next five days. Four doses at four-hour intervals were used. Equal amounts of bicarbonate of soda were administered with the drug. Minor toxic reactions were noticed, about 25% of the patients complaining of nausea and dizziness. In the second half of the series the total amount of drug was raised to 21 grams. Four grams a day were given the first two days, three grams a day for the next three days, and 2 grams for the last two days. Toxic reactions were much more frequent on this schedule but none were serious enough to stop the treatment. Blood counts were carried out at 2-3 day intervals during treatment. Smears were examined on three occasions at the end of the course of therapy.

The results of treatment in this group of cases can be summarized as follows: Negative spreads were found in 95.6% of the cases. Eight cases or 6.4% continued to show positive spreads, four of them after repeated courses of treatment. In three of the failures fever therapy was used with successful results in two instances. Smears were found to become negative about the fourth day of treatment. Acute cervicitis and urethritis improved rapidly, in successful treatments appearing clinically cured at the seventh day. No unfavorable effects were noted in the patients who were pregnant.

Cases with salpingitis showing positive spreads were classified into three groups, (1) Initial attack of acute salpingitis, (2) Recurrent acute salpingitis, (3) Chronic salpingitis. In the 69 acute cases 60% showed marked improvement in the amount of adnexal tenderness and thickening, 20% showed moderate improvement, while 20% were unimproved. In the 26 cases of recurrent disease, only 20% showed marked improvement, 50% moderate improvement, and 30% remained unimproved. In the chronic cases no effect was noted which was also true of the group of cases with salpingitis, negative spreads and positive complement fixation tests. We have yet to see a large inflammatory adnexal mass disappear rapidly under chemotherapy. In 73 instances the sedimentation rate was rapid and in 50% it became normal after a week of therapy. The follow-up on these patients was so poor that it is not worth reporting. Gurnee, however, at the time of the report had seen no recurrences or reinfections in successfully treated cases.

Bowen¹⁷ in 1939-1940 studied 55 more cases with positive spreads on the Gynecological Service at Bellevue Hospital. Approximately the same dosage

of sulfanilamide was used in the treatment of these patients as was used in the last half of the first series. He found that 80% showed negative spreads after one course of sulfanilamide. When a similar course of sulfapyradine was administered to the failures an additional 16% showed negative spreads, bringing the apparently successful results to 96%. Sulfapyradine, however, proved objectionable because of the occurrence of marked nausea and vomiting in a large proportion of patients, but seemed effective in a certain proportion of infections not improved by sulfanilamide. His other observations agree with those of Gurnee and Walker.

At present Barrows and Labate are studying the effects of sulfathiazole on a large group of cases. Their impression is that sulfathiazole given in 1 gram doses four times a day for one week produces practically no toxic symptoms and they have noted only one failure in 39 cases with demonstrable infection. No better results than those previously noted have been obtained in patients with salpingitis.

It is to be noted that all of these cases have been hospitalized. Study of patients receiving ambulatory treatment in the O. P. D. reveals markedly inferior results. Although Lewis¹⁸ believes he can treat ambulatory patients successfully with sulfathiazole, we still believe that hospitalization will yield the best results, and should protect the patient from the uncommon toxic reactions.

As has been stated, these results are partially invalidated by the poor follow-up and a failure to use cultures. Douglas,¹⁵ however, in a much smaller but excellently controlled series achieved bacteriological cures in 94% of patients treated with sulfanilamide. He used 4-6 frams a day for a period of seven days. By taking frequent cultures he found that the cervix became negative in 24 hours, the urethra in eleven. The unpleasant effects and the toxic actions of this drug, together with the possibility of faulty action in this infection as pointed out by Van Slyke,¹⁹ have caused most clinicians to abandon the use of this drug. The use of sulfapyridine went through a brief phase. Today sulfathiazole^{18,20,21} appears to be the drug of choice because of its effectiveness and lack of toxicity.

There appears to be no adequate explanation of the relatively few failures to attain a cure. Our experience leads us to believe that little can be accomplished in these cases by prolonging treatment with

or by repeating courses of the same drug. Another sulfonamide should be used. Should all these drugs fail, simple fever treatment has been successful in some instances on the Bellevue Service. It has also been suggested that fever therapy be preceded by a short period of chemotherapy.²⁰ These methods should further reduce our incidence of failure.

It is apparent that we have in our minds at last agents that will, in the vast majority of instances, cure gonorrheal infections in the female in the acute stages of the disease. Theoretically we should be able to prevent or arrest the majority of cases of acute salpingitis. This goal, however, still lies in the future and will be attained only by organized medical effort and lay education. We have seen no evidence of a decrease of adnexal infections in the wards of Bellevue Hospital up to the present. In 1937-1938, 770 cases were admitted, 33% of them coming to operation; in 1938-1939, 883 cases, 32% being operated; while in 1939-1940, 836 cases were admitted, 38% being surgically treated.

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THE FUNCTION OF THE BILE WITH SPECIAL REFERENCE TO THE THERAPEUTIC USE OF BILE SALTS

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BILE is the characteristic product of the liver, the largest gland in the body. The early physiologists argued at length as to whether bile was a secretion or an excretion. The adherents of both schools of thought were correct, to a degree, for it is now recognized that bile is a complex fluid containing materials of various origin and function. The most characteristic constituents are the bile acids and bile pigments, but in addition, cholesterol and the other lipoids, mucin, inorganic salts and various compounds excreted by the liver which are part of its detoxifying or excretory function, are present.

The bile pigments represent the end stage of hemoglobin metabolism. This breakdown takes place primarily in the cells of the reticulo-endothelial system so that the bilirubin in the bile is excrementitious.

The bile acids, on the other hand, represent a true secretion of the liver. Several different bile acids are known to exist in nature, and their chemical constitution has been under investigation for a long time. In the past few years this field of chemistry has been revolutionized, and the structural formulas not only of the bile acids but of many chemically related compounds now are known. This subject has recently been reviewed in detail by Sobotka.¹ Reference must be made to his review for details, for Sobotka reports that over five hundred compounds chemically related to the bile acids have been described and cites over three hundred references in his bibliography.

The bile acids are derivatives of the polycyclic hydrocarbon, cholane, which is related to the phenanthrene compounds. Interest in these compounds is heightened by the recognition that many other compounds of great biological and medical interest

have this same tetracyclic carbon skeleton. Thus, the bile acids of both the cholic and the deoxycholic acid series and their derivatives; the various sterols such as cholesterol, phytosterol, ergosterol and Vitamin D; the aglucone group of various glucosides, such as saponin, digitalis, strophanthin, and some of the toad poisons; some hormones, including those of the ovary, testis, corpus luteum and adrenal cortex and certain carcinogenic substances prepared synthetically or isolated from coal tar are all related chemically.

The physiologic or pharmacologic action of many of these compounds has been studied in detail, but much necessary biochemical knowledge is lacking. At present the course of the synthesis of these compounds in the body and the manner and method of their catabolism are unknown. There has been much speculation in consequence regarding their biochemical relationship, if any. Are they mutually interconvertible; if so, which ones? Particularly fascinating is the suggestion that a disturbance in or a perversion of the normal catabolism of bile acids or of cholesterol might lead to the formation of carcinogenic compounds in significant amounts. It must be kept in mind that until more is known of the metabolism of these compounds, there is no direct evidence to support such an hypothesis.

The importance of bile in the absorption of fats is well understood.^{2,3,4} This is partly due to its action in activating pancreatic lipase and partly to the action of the bile salts in favoring emulsification and solution of the fats. Wieland and Sorge⁵ showed that the so-called choleic acids in bile really are addition compounds of deoxycholic acid with fatty acids. Verzar and Kuthy⁶ have emphasized the importance of such compounds in the absorption and transport of fatty acids, for they are water-soluble and may be absorbed directly into the portal circulation. Drummond adds further emphasis by stating that "The most important function of the bile is to facilitate the absorption of fatty substances by the formation of these curious complexes with bile acids." It is clear that the property of the bile

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acids in favoring the absorption of fatty substances is not limited to the true fats but is extended to a large series of "fat-soluble" materials. Drummond cites experiments showing the absorption of such unrelated compounds as liquid petroleum and naphthalene.

The practical importance of this aspect of the absorption of "fat-soluble" materials is apparent when the vitamins are considered. Wright and Whipple⁷ reinvestigated the absorption of cholesterol after oral administration to dogs and showed that the excretion through a biliary fistula is increased by the feeding of bile or bile salts with the cholesterol. Greaves and Schmidt⁸ have shown that in rats the absorption of Vitamin D is deficient when bile is excluded from the intestinal tract.

Greaves and Schmidt⁹ placed rats on a diet deficient in Vitamin A and then excluded bile from the intestinal tract either by ligation of the common bile duct or by the production of a biliary fistula. Tests showed that these animals were able to absorb Vitamin A in the absence of bile from the intestinal tract. The carotins (alpha, beta, gamma) are now recognized as being precursors of Vitamin A and are frequently referred to as pre-Vitamins. Carotin administered orally was not absorbed when bile was excluded from the intestine. Carotin forms addition compounds with desoxycholic acid and so was absorbed when administered with desoxycholic acid. Animals with experimental obstructive jaundice were unable to convert carotin into Vitamin A. These experiments, therefore, strengthen the view that the liver is the organ which converts carotin into Vitamin A.

Clinicians have long recognized the variety and severity of the nutritional disturbances seen in obstructive jaundice. That some of these symptoms may be produced by a deficiency of Vitamin A has not been recognized so clearly. Áltshule¹⁰ observed histological evidence of a deficiency of Vitamin A in the postmortem study of infants with congenital atresia of the bile ducts. Studies have been carried out in cases of obstructive jaundice in adults and in cases of cirrhosis which also give evidence of defective absorption and utilization of Vitamin A.^{11,12,13,14,15,16}

The earlier literature dealing with the relationship between prothrombin deficiency and the bleeding tendency of jaundiced patients and the importance of the administration of bile salts and Vitamin K in correcting this disturbance was reported in the re-

view of 1938.^{17a} Since then, the literature dealing with various phases of this problem has increased voluminously.^{17b} The most important development has been the isolation of Vitamin K in crystalline form, the determination of its chemical structure and its chemical synthesis. This goal was reached practically simultaneously by several different groups of investigators and accounts of this dramatic race have been reported by Fieser and by Doisy and his associates.

These studies established that Vitamin K, prepared from alfalfa, is 2 methyl, 3 phytyl, 1,4 naphthoquinone. An extensive study of the activity of related naphthoquinones showed that 2 methyl, 1,4 naphthoquinone was the most active of these and was at least as efficient as the naturally occurring Vitamin K. Since it is slightly water soluble, it can be given intravenously. When given by mouth, it may be absorbed more readily than the natural Vitamin K. The clinical use of 2 methyl, 1,4 naphthoquinone in the treatment of prothrombin deficiency has been reported by a series of investigators. Doses of from 0.6 to 10 mg. daily have sufficed to control hemorrhagic phenomena and restore the prothrombin time to normal. No toxic effects have been reported and while further study is required, the introduction of this compound into clinical practice apparently represents a real therapeutic triumph.

Recent studies on the physiology of the bile acids may be summarized under several different headings. (1) Experimental and clinical studies on the effect of diet on the secretion of bile; (2) The post-operative concentration of bile salts in human bile; (3) The excretion of intravenously injected cholates; (4) Experimental and clinical studies on the effect of the administration of bile salts on the composition of the bile; and (5) The therapeutic use of bile salt preparations.

Ivy and his associates¹⁸ report that by further improvements in the detail of the methods of collecting bile from animals with experimental biliary fistulae they have been able to obtain consistent and reproducible results under similar experimental conditions. They used female dogs and prepared their bile fistulae by a modification of the method of Rous and McMaster.¹⁹ During the experimental period, continuous suction was applied to the fistula tube to prevent possible blocking. Using this method, Kocur and Ivy report that under similar experimental conditions the secretion of bile did not vary more than 4 per cent. They report that the volume of bile

secreted by the liver under controlled experimental conditions is as constant as the secretion of any of the external secretory glands.

The secretion of bile varied with the diet and the amount of bile returned to the intestine. It was lowest (6 to 10 c.c./Kg/day) when the animal was fasting and there was no return of bile. On a mixed diet but without return of bile, the output ranged from 13 to 18 cc./Kg/day, whereas on a mixed diet with a return of a standard amount of bile to the intestine it ranged from 24 to 27 cc./Kg/day.

Hot weather had no effect on the volume of the bile when the appetite was unimpaired. The drinking of water or the intravenous injection of 0.5 per cent NaCl solution likewise was without effect.

A mixed diet stimulated the output of bile. Meat was the most potent food whether taken alone or added to a mixed diet. Beef liver was more effective than muscle or beef heart. Olive oil increased the output of bile in fasting dogs but this effect was not observed when the dose was repeated or if the olive oil was added to a mixed diet. Glucose administered to a fasting animal produced a 20 to 30 per cent decrease in the output of bile. When glucose was added to a mixed diet, there was no characteristic change in the secretion of bile. However, if the secretion of the liver was stimulated by the giving of bile and glucose was then injected intravenously, the secretion of bile was increased.

The most marked increases in the volume of the bile followed the administration of bile itself. Because of the greater concentration of bile acids, gall bladder bile was a stronger stimulant than hepatic duct bile.

Schmidt, Beazell, Berman, Ivy and Atkinson^{20,21} continued these studies but in addition to measuring the volume of the bile they also determined the daily excretion of bile acids as cholates and of cholesterol and pigment. Under standard conditions without return of the excreted bile, the output of these various biliary constituents was quite constant. The daily output of bile acids varied from 1.2 to 1.9 grams but when all the bile was returned to the duodenum the output was increased to 6.5 to 9.0 grams. From this, Ivy and his associates concluded that while there is an active entero-hepatic circulation of bile acids, from 10 to 15 per cent are lost on each circuit. This loss is compensated by that formed endogenously and from the diet so that the output is more or less constant.

Atropine and Beta-methyl-acetyl choline prevented the increase in volume and cholates that normally followed a mixed meal.

Companion studies in patients with bile fistulas have been reported by Zuckerman, Kogut, and Jacobi²² who showed that in a patient with an apparently normal liver, the hourly rate of flow was fairly regular except for a slight diminution during the night. The rate of secretion was not affected by changes in the intake of water. When carbohydrate was fed, there was no increase in the volume of bile. A mixed hospital diet or a high fat diet produced a moderate increase in the output of bile but the most marked change followed the use of a high protein diet. The oral administration of bile produced a further increase in bile output that was in most instances independent of the food. When a maximal choleresis had been produced by a high protein diet, bile was less effective in increasing this response.

The insertion of a T tube and drainage of the common bile duct permits the study of human bile. During the past 10 years there has been an increasing number of such reports. For the most part these reports have been concerned with the secretion of bile salts by the liver during the first week or two after the insertion of the drainage tube.²³ Greene, Hotz, Carter and Twiss,²⁴ who have made the most recent study of this problem, point out that there is general agreement that, when the patient has had no evidence of hepatic disease or the latter is minimal, a temporary post-operative reduction in the concentration of cholates in the bile is followed after two or three days by a progressive return to normal levels. This post-operative drop apparently is due to the individual or combined effects of a variety of different factors. The anesthetic agent and the duration of anesthesia, the local as well as the constitutional effects of the operative trauma, the degree of pre-operative biliary obstruction and hydrohepatosis, and the like, must all be taken into consideration in interpreting results.

Following the initial post-operative drop, the concentration of cholates in the bile returns toward the normal. The rapidity of this return and the maximal concentration attained during the period of observation, in general are inversely proportional to the degree of hepatic damage. The hepatic damage may be evidenced by structural changes such as cirrhosis, but Greene, Hotz, Carter and Twiss point out that functional insufficiency may be present without gross pathological changes being evident.

They present evidence that such factors as systemic infection, fever, cholangitis, depletion of bile salts from prolonged drainage, or an inadequate supply of carbohydrate, will reduce the concentration of cholates in the bile presumably as a result of functional disturbance. They confirm the report of Greene, Frederickson and Walters that the continued failure of the liver to secrete bile acids is evidence of severe functional disturbance and so may be of serious prognostic import.

These studies of the post-operative changes in the concentration of bile salts in the bile are important for they indicate the multiplicity of factors which affect the functional activity of the liver. The multiplicity of these factors, however, greatly increases the difficulty of determining the ones responsible for the changes in any individual case.

Bile acids whether administered by mouth or intravenously are rapidly and quantitatively excreted in the bile. This was suggested by the early studies of Stadelman,²⁵ Kuhne²⁶ and Huppert.²⁷ Greene and Snell²⁸ studied the process in more detail and emphasized the rapidity with which intravenously injected bile acids disappeared from the blood stream. The time required for their removal varied with the dose, but even with maximal doses the greater part of the injected bile acids were removed from the blood within 30 minutes. Excretion in the bile likewise was rapid but showed a definite delay, for the peak of the excretion did not come until after the blood had returned to normal. This problem has been studied further by Snell, Greene and Rowntree,²⁹ Bollman and Mann,³⁰ Chabrol, Cottet and Sallet³¹ and by Lichtman³² with similar results. More recently it has been reinvestigated by Josephson and his associates³³ who studied the fates of injected sodium cholate under various experimental conditions. They found in confirmation of the earlier studies, that intravenously injected sodium cholate usually was removed from the blood stream in about 30 minutes.

The intravenous injection of a solution of sodium cholate in patients with jaundice produced a greater rise in the cholic acid content of the blood than in normals. Patients with obstructive jaundice showed a moderately rapid fall in the cholic acid content of the blood and the initial level usually was regained at the end of the hour. In cases of acute hepatitis, the reduction in the blood levels was greatly delayed and the values were still elevated at the end of an hour. Josephson recommends the test as valuable

in the differential diagnosis between these two types of jaundice though examination of the tables show considerable overlapping between the different groups.

The study of the effect of bile salts and of various therapeutic agents on the volume and composition of the bile was extended by Schmidt, Beazell, Atkinson and Ivy.³⁴ The various types of response obtained makes it desirable for the physician as well as the physiologist to distinguish between three related effects on the liver and biliary tract.

Cholagogues stimulate the evacuation of the gall bladder and increase the flow of bile into the intestine but do not increase the rate of secretion by the liver.

Hydrocholeretics increase the volume of the bile but do not stimulate the secretion of biliary constituents.

Choleretics produce an increased flow of bile and an increased elimination of biliary constituents.

Schmidt, Beazell, Atkinson and Ivy studied the effect of a number of drugs on the secretion of bile. Calomel has long had a reputation based upon its reputed clinical effectiveness in cases of "biliousness" or of "torpid" livers. This has not been confirmed by previous experimental work. In the present study, calomel in doses of 100 mg. had no effect on either the volume or the constituents of the bile. Ammonium chloride, urea, calcium gluconate, mucin, chondroitin and sulfanilamide were tested and all found to be without significant effect on the secretion of bile. The authors found as have other investigators that sulfanilamide was eliminated in the bile in concentrations that have been reported to be bacteriostatic.

Salicylic acid, administered as aspirin, increased the volume of the bile by approximately 59 per cent but the excretion of cholates was reduced slightly.

Oxidized unconjugated bile acid derivatives such as Decholin and Ketochole acted as hydrocholeretics for they more than doubled the volume of the bile but reduced the excretion of cholates by approximately a third.

Conjugated Ketocholeic acids (Dechacid) had a moderate choleretic action for the volume of the bile was increased. The excretion of cholates was not changed but because of the excretion of administered Ketocholeic acids, the total bile acid output was increased.

The normally occurring conjugated cholic acids (Bilron) and dog bile were the most satisfactory

choleretics for they produced both an increased flow of bile and an increased excretion of bile salts. In the latter case, it must be remembered that the increase was due to the elimination of administered cholates and not to an increased synthesis of bile acids.

Doubilet³⁵ also reported a study of the hepatic excretion in dogs following oral administration of various bile acids. When cholic acid was administered, there was a marked increase in the excretion of cholic acid and some increase of desoxycholic acid. The administration of desoxycholate increased its own excretion but depressed the excretion of cholates. He measured the efficiency of the liver by the maximum excretion of bile acids in the smallest volume of bile. Using this index, the order of decreasing efficiency in the dog was dog bile, ox bile, glycocholic acid, cholic acid, desoxycholic acid and dehydrocholic acid.

Riegel, Ravdin and Prushankin³⁶ studied the effect of dehydrocholic acid in five dogs and report that in all there was an increase in the volume of bile, 71 per cent on the average. There was very little change in the excretion of cholesterol but a slight increase (20 per cent) in the excretion of cholates. This last finding is at variance with the results of Doubilet and of Schmidt, et al. While there was a slight change in the cholates, the more marked increase in the volume of bile still seems to classify the response as hydro-choleretic.

The rational therapeutic use of bile salts depends on an understanding of their functions and activities in the body. These have been discussed in detail in recent articles by Ivy and Berman.³⁷ They point out that (1) The bile salts promote the formation of bile. They increase the volume of bile and the output of cholesterol and bile salts but do not effect the excretion of pigment. All, or all but about 10 per cent of administered natural bile salts, are re-excreted in the bile. (2) Bile salts by keeping fatty acids in solution may act to prevent the precipitation of cholesterol and fatty acids in the gall bladder. (3) The natural bile salts aid in the digestion and absorption of fats. (4) Natural bile salts facilitate the absorption of iron and calcium and are necessary for the absorption of carotene, cholesterol and of vitamins D, E, and K. (5) Bile salts administered orally may stimulate gastric peristalsis and may have a laxative action. (6) Bile salts are said to play a role in detoxifying bacterial toxins in the intestinal tract. (7) Bile salts may affect the storage of glycogen by the liver.

Ivy and Berman discuss the therapeutic use of bile salts under these several headings. They point out that (1) In the absence of bile from the intestine, the oral administration of bile salts is indicated to improve digestion and absorption. The profound digestive and nutritional disturbances observable in patients with complete biliary fistulae or with complete biliary obstruction and the symptomatic relief obtained from the administration of bile salts in adequate dosage is evidence for the truth of this recommendation. The importance of giving bile salts together with Vitamin K in the pre-operative preparation of jaundiced patients is recognized. The possible harmfulness of the administration of bile salts to a patient with complete biliary obstruction was considered by Ivy and Berman. They point out that clinical experience has demonstrated that oral administration for short periods of time was without evident deleterious effects. They obtained similar results in a few prolonged animal experiments. The earlier studies of Brakefield and Schmidt³⁸ and the more recent ones of Mann and Bollman, showing that in dogs with obstructive jaundice there is a rapid excretion in the urine of orally administered bile acids may explain the apparent absence of toxic effects in such patients.

We wish to emphasize the difference between the administration of bile salts in adequate dosage in the presence of a demonstrated deficiency of bile in the intestine and the widespread popular use of bile containing pills for the relief of "biliousness" or a "sluggish liver." Too often the condition which the patient seeks to correct is one of constipation. Bile preparations in adequate dosage will increase peristalsis in both the stomach and colon and so have a direct laxative effect but the usually recommended dose is too small to produce such an effect.³⁹ The therapeutic benefit experienced from the use of many commercial preparations is due to the presence in the preparation of active cathartics such as aloin, phenolphthalein and the like and not to the minute amounts of bile salts which are included. (2) In disease of the biliary tract without acute hepatitis, bile salts may be administered to flush the biliary passages with a copious flow of bile of low viscosity. This use of bile salts is rational in so far as the bile ducts are concerned; a brisk flow of bile through the hepatic ducts would tend to prevent ascending infection. We agree as to the value of bile salts as a post-operative measure in cases in which T-tube drainage of an infected common duct has been instituted. Because of their hydrocholeretic

effect, it is possible that the oxidized bile acid derivatives such as ketochol and decholin are preferable to the natural bile acids in this condition. Flushing of the ducts is less certain in the unoperated patient, for a hypertonic sphincter of Oddi theoretically might prevent a free flow of bile. However, Ivy and Goldman⁴⁰ point out that spasm of the sphincter is less readily produced if the liver is secreting freely.

Flushing of the gall bladder is a different problem from flushing of the bile ducts. The extent to which the administration of bile will change the chemistry of bile in the gall bladder and will flush out the gall bladder is uncertain. It also must be remembered that in cases of either acute or chronic cholecystitis in which the gall bladder does not fill, a copious flow of bile could only accomplish a flushing of the bile ducts.

(3) In the presence of disease of the biliary tract and acute hepatitis, the use of bile salts has been implied to be of benefit by a number of clinical observers. Ivy and Berman insist that until more unequivocal observations become available, they doubt the wisdom of bile salt therapy in such conditions except for the purpose of improving intestinal absorption. The previously reported studies have shown that the presence of cholangitis reduces or abolishes the choleretic effect of bile salt preparations and injected bile salts are not removed from the blood stream at the normal rate. We have been informed of one case of possible acute yellow atrophy following the intravenous administration of a preparation of oxidized bile salts. Under these conditions, we wish to second this plea for caution in the therapeutic use of bile salts except where it can be shown that there are specific scientific indications for such use.

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THE BELLADONNA ROOT TREATMENT OF CHRONIC ENCEPHALITIS

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AMONG THE common chronic diseases confronting the profession is postencephalitic Parkinsonism. We do not yet know how to halt the process or how to prevent its forerunner. However, in recent years, workers have found that the extracts of belladonna root and similar products are of definite benefit in the palliative treatment of chronic encephalitis. The pioneer in this work was Ivan Raëff, a plant collector in the Bulgarian village of Chipka, and his experiments date back about 15 years.

The exact manner in which Parkinsonism arises is not known. Bing¹ refers to the work of Wimmer, Spatz and Jakob in which it is stated that the originally acute inflammatory process becomes more progressively chronic. He also mentions the studies of Buscaino, Stern and Ottenelo. These suggest that abnormal metabolic processes which are initiated during the acute stage of encephalitis continue to exert a toxic action which finds clinical expression at some later date. Bing and Pette feel that postencephalitic Parkinsonism is an expression of gradual exhaustion: i. e., an abiotrophic destruction of the basal ganglia which had been damaged initially during the acute stage of encephalitis. Unfortunately, these theories have not led to the formulation of a cure.

The basal ganglia are interesting brain structures. To date, opinions regarding the exactness of their components and their functions vary. Kuntz² states that the basal ganglia are the gray masses which constitute the caudate, lentiform and amygdaloid nuclei and the claustrum, and they are more or less completely embedded in the white medullary substance of the hemisphere. To these, Brock³ adds the thalami and he mentions such well known structures as the subthalamic body (*Corpus Luysi*), the substantia nigra and the red nucleus which may be regarded as functionally related. These ganglia and their fibers are called the extrapyramidal system which is phylogenetically older than the corticospinal or

pyramidal system. It is believed that the newer corticospinal system inhibits the older one. Brock goes on to say that muscle contractions dependent upon pyramidal tract activity are phasic, non-postural and modifiable, whereas those mediated by the strio-rubro-spinal system are static, automatic, postural and fixed. Both pathways inhibit tone; when both are destroyed by disease, the hypertonus is extreme. Parkinsonism is one of the most common affections of the strio-pallidum. One-sided or bilateral rigidity of the muscles and a coarse tremor are the outstanding features. For further studies on the functions of the basal ganglia, the reader is referred to studies by the late S. A. Kinnier Wilson.⁴

For many years, the use of atropine and its derivatives in chronic encephalitis has been reported and with variable results. The atropine group consists of hyoscyamine, belladonna, stramonium and scopolamine or hyoscine. The action of each of these is not alike. It is known that atropine stimulates the motor centers of the brain, the midbrain and the medulla. It is believed that a secondary depression effect follows the primary stimulation. Hyoscine, on the other hand, produces a sedative effect on the higher centers. Hyoscyamine is rarely obtainable in pure form, as it is almost always mixed with atropine. Cushny⁵ states that the motor centers respond more readily to electrical stimulation after atropine. In the study to be described below, the author used Rabellon* in tablet form. This synthetic preparation contains in liquid form three milligrams of total alkaloids per c.c. The 0.5 mg. tablet is composed of hyoscine hydrobromide, atropine sulfate and scopolamine hydrobromide.

At the present time, there is ample and increasing literature which describes the good results obtained from the Bulgarian treatment of chronic encephalitis. Panegrossi,⁶ Neuwahl,⁷ Fabing,⁸ Draper,⁹ Vollmer,¹⁰ Gayle,¹¹ Neall¹² have all reported favorably on the use of the belladonna root and like preparations. It is interesting to note that good results from

*One Rabellon tablet is equivalent to 0.5 milligrams of total alkaloids. A trial supply for this study was furnished through the courtesy of Sharp and Dohme.

treatment with belladonna roots grown in other countries have also been obtained. Neuwahl and Fenwick¹³ state that the advantage of this substance may be due to (a) the potentially stronger action of a decoction of the whole root; (b) the possible presence of intermediate alkaloidal products; (c) buffer substances which lower toxicity, equalize absorption and prolong the effect. It is reported that treatment by belladonna root products benefits not only the rigidity and tremor but also excessive salivation, speech disturbances, oculogyric crises, skin changes and certain untoward emotional reactions.

About one year ago, the author introduced the use of Rabellon to eleven patients recruited from clinic and private practice. Eight of these presented definite history of influenza, two were vague and one belonged to the arteriosclerotic group. In no cases did signs and symptoms permanently disappear.

REPORT OF CASES

Case 1. L. S., male, aged 37, had influenza in 1918. Present illness appeared in 1931. Symptoms became so severe that patient became addicted to sodium amytal and threatened suicide on many occasions. He was given Rabellon, one tablet at 9 A. M., 12 noon, 3 P. M. and 6 P. M. Objectively, he presented: Facies brighter, speech more distinguishable, vocal tone better, gait easier, tremor greatly decreased, oculogyric crises absent, skin cleaner and mood much better. Subjectively: "My eyes seem to be getting stronger, my speech is better and I don't stutter so much, I can walk better, my stride is better, I feel less nervous, the tremors are about the same." A most remarkable reaction occurred in this case. About eight months after treatment began, patient had a spontaneous total remission for a period of two weeks. His family and the neighborhood believed that a miracle had been performed! The author is at loss to explain this although one may hope that some day, this process may be found to be reversible.

Case 2. T. B., male, aged 29, remembers having had influenza but cannot give the date. Present illness appeared in 1928. Patient takes Rabellon, one tablet every three hours for 3 doses daily. He formerly received stramonium, benzedrine and cobra venom. Objectively: Voice shows better modulation, facies are relaxed and smiling, tremor is markedly reduced permitting some fine work. Subjectively: "It makes me walk better, makes me talk better, it gives me a little more life, I shake less."

Case 3. J. T., female, aged 45, suffered from influenzal attack about 1919. Present illness commenced in 1935 and is mild. Is taking Rabellon, 3 tablets a day. Objectively: Facies are relaxed and more expressive, tremor is practically absent, gait is much livelier, muscular strength is improved. Subjectively: "My legs don't shake so much, I feel better, I feel stronger, I can walk better."

Case 4 J. K., female, aged 34. Influenza in 1925. Present illness began in 1931 and is severe. Patient's cooperation and

statements are doubtful. For a while, she had been taking 8-10 stramonium pills a day. She is now receiving one Rabellon tablet t.i.d. Objectively: Oculogyric crises markedly diminished in frequency and intensity, speech is now quite distinct, though rapid, vocal tone is better, tremor is much decreased, general appearance exhibits definite improvement, expression of suffering is now absent. Subjectively: "I talk stronger, I walk better, I feel better, it makes my mouth dry."

Case 5. G. B., female, aged 40. There is no definite history. Present illness commenced about 1930 and is severe. Patient takes $\frac{1}{2}$ Rabellon tablet every three hours for 5 doses. Objectively: Patient can now smile freely, face shows greater expression, gait is much improved, is now able to climb stairs without difficulty, voice shows better tone, oculogyric crises are gone, tremor is at times totally absent and when present is much finer, muscular energy is greatly increased. Subjectively: "I feel pretty good, I can walk better, I talk better, at times I don't drag my foot, I feel better when I take that kind of medicine."

Case 6. V. S., male, aged 49, severe influenza in 1923. Onset of present illness was insidious and patient was regarded as a neurotic for many years. Signs and symptoms are minimal. Patient is taking $\frac{1}{2}$ Rabellon tablet every 3 hours for 4 doses. Objectively: There is steady gain in weight, gait is much livelier and facies show some expression. Subjectively: "I still feel dizzy, I feel sick, I feel weak." There is a suggestion of an underlying depression with mental deterioration in this case.

Case 7. W. V., male, aged 60. Patient has had arteriosclerotic Parkinson's disease for about 5 years. He is deteriorated, combative, and commitment has been considered. Patient received $\frac{1}{2}$ Rabellon table five times a day. Objectively: General activity is increased, tremor is decreased, voice is stronger and clearer, gait is better. However, there is an accentuation of an undesirable mental trend. Patient is insulting, antagonistic, irritable and negativistic. After two weeks he refused medication. Subjectively: "I don't want that d— medicine."

Case 8. L. B., male, aged 60. Influenza in 1932. Advanced arteriosclerosis. Onset of present illness about 3 years ago and rapidly progressive with marked psychomotor depression. Rabellon has had to be stopped and the dose changed several times owing to a distressing tachycardia. Patient is now receiving $\frac{1}{2}$ tablet t.i.d without ill effects. Objectively: Remarkable improvement in general muscle tone, improvement in appetite with slight gain of weight, disappearance of shuffling gait, greater knee flexibility, facies relaxed and with more expression, tremor markedly diminished unless upset emotionally. Subjectively: "I feel like working again, I feel much better, I can walk better, I feel lighter, I feel stronger, I guess I'm going to be all right, (patient told medication offers only relief), don't I look better?" Arteriosclerotic changes are making rapid progress.

Case 9. A. R., female, aged 50. Influenza in 1932. Present illness commenced in 1933 and is mild. Patient takes $\frac{1}{2}$ Rabellon tablet 5 times daily. Objectively: Body tone is much improved, tremor is markedly diminished, speech is stronger, feeling of resignation is unchanged, (patient knows a good deal about the disease). Subjectively: "My hand is stronger and steadier, I can write better, it quiets me down quicker,

my mouth isn't cramped up, my hand doesn't shake so much, my mouth is a bit dry, it is easier for me to rest, I still can't sleep."

Case 10. M. K., female, aged 56. Influenza in 1929. Onset of present illness in 1930 and now severe with marked mental depression and death wish. There are advanced hypertensive changes. Patient takes 3 Rabellon tablets daily in divided doses. Objectively: Remarkable improvement in gait so can walk unassisted, tremor is practically absent, voice is now clear and resonant, patient shows cheerful facies and smiles frequently, fine movements are performed with moderate ease, (husband must now prevent her from doing her own washing), there is an increase in general activity, muscular strength is improved. Subjectively: "I'm well, I can walk better, I do a little better, I am happier, I am getting fat, I make better meals." Three days after the onset of treatment, patient began to complain of distressing mouth dryness, blurred vision and her family observed that she had attacks of euphoria with laughter and uncontrollable manic trends. This reaction subsided in 48 hours without altering medication schedule. In the last few months, the gains have levelled off and although she is more labile physically and can get around better, mood has sunk to a deplorable level.

Case 11. S. S., female, aged 65. No definite history of influenza. Present illness began about 15 years ago and is severe. The patient has been almost totally immobile for 5 years. She is taking one Rabellon tablet every 3 hours for 4 doses. Objectively: Patient shows a little more voluntary movement in all limbs and can slightly rotate her head, (Joint changes are pronounced). Subjectively: "Doctor, I feel about the same."

SUMMARY

Postencephalitic Parkinsonism is a chronic inflammatory disease of the basal ganglia producing hypertonus, tremor and other distressing symptoms. Treatment is symptomatic and difficult as in most chronic diseases of unknown etiology. The use of atropine derivatives which has enjoyed the greatest support has been modified recently when it was learned that root extracts produce a better effect. Atropine pharmacologically is known to stimulate the higher motor centers of the brain and to depress parasympathetic function and these actions explain its value in Parkinsonism.

In our small series of eleven patients, eight had influenza, two did not recall having had the disease and one presented paralysis agitans. All were given a

synthetic product similar to the belladonna root. Practically all of the postencephalitic patients were improved while the one with paralysis agitans did not react favorably. I am at loss to explain the full remission for two weeks in one patient.

Greater ease in motion, improvement in speech and vocal tone, lessening of the tremor and salivation, decrease or absence of oculogyric crises and elevation of mood are regarded as good results.

Patients should be told that the "new" medicine is not a cure, that if it helps then it will have to be taken for an indefinite period, that they must avoid alcohol and decrease or eliminate smoking. Attention to good habits of health is stressed at all times.

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PROGRESS REPORT ON EXPERIMENT IN CONTROL OF CANCER OF THE UTERUS

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CANCER of the uterus is one of the major problems of gynecology because cancer occurs more often in the uterus than in any other organ. In the uterus, cancer occurs in two forms—cancer of the cervix and cancer of the body. Cancer of the body of the uterus occurs in later life. The results of treatment in this form are very good. Cancer of the cervix occurs in middle life and is about four times as frequent as cancer of the body. The results of treatment in this form are poor. Since the cervix is so readily accessible to examination and to treatment, it seems that this situation might be improved.

For the past three years, my associates, Doctor Margaret C. Sturgis, Doctor Faith S. Fetterman, and I of the Department of Gynecology of the Woman's Medical College of Pennsylvania have been engaged in an "Experiment in the Control of Cancer of the Uterus." This experiment is particularly concerned with cancer of the uterine cervix and is based upon two major premises:

1. That cancer of the uterine cervix begins as a small and sharply localized area of disease and that, if discovered and adequately treated in this early stage, it can be completely and permanently cured.
2. That cancer of the uterine cervix begins in diseased tissue and that by eliminating areas of "epithelial restlessness" such as cervicitis and cervical erosion, its development can be prevented.

In a book on the "Diseases of Women" published in Philadelphia in 1853, the author, a long since forgotten gynecologist, reports a series of cases of cancer of the uterus, tells of the symptoms and pelvic findings and describes his method of treatment. This consisted simply in cutting away masses of diseased tissue. Some of his patients died promptly from

hemorrhage. Not one of them was cured. At the end of the chapter, the author states "If these women had come earlier, perhaps some of them might have been cured." That was in Philadelphia in 1853.

With the gradual perfection of anesthesia, with the gradual perfection of the aseptic technique, the surgical treatment of cancer of the uterus came to be regarded as a reasonably safe procedure rather than as a dangerous last resort. The technique of the operation for cancer of the cervix reached its highest development in Vienna in 1898 at the hands of a great gynecologist—Professor Ernst Wertheim. After twelve years trial of this method, Professor Wertheim reported a series of five hundred cases with 18% of five years cures. At the end of a monograph on this subject published in Vienna in 1911, he expressed the opinion that better results might be obtained if patients came earlier for operation. That was in Vienna in 1911.

With the discovery of the Roentgen Ray in 1895, with the discovery of radium in 1898, the treatment of cancer of the uterus received a powerful stimulus. First used as adjuvants to surgery, these agents are now used alone and in preference to surgery in most cases of cancer of the cervix. In a book on gynecology edited by Doctor Fred L. Adair and published in Philadelphia in 1940, the statement is made that the irradiation treatment of cancer of the cervix results in less than 25% of five year cures. The need for early treatment is emphasized and the indications for early medical consultation are stressed. This was in Philadelphia in 1940.

From these statements it appears that the medical profession has recognized the importance of early treatment in cancer of the uterus for at least 87 years. What has been done to accomplish this?

The first organized effort to educate the lay public concerning cancer was undertaken in East Prussia where Georg Winter, Professor of Gynecology at

the University of Koenigeberg organized a "Crusade Against Cancer." This example was soon followed in this country with the formation of the American Society for the Control of Cancer in 1914. Since then, in my own neighborhood, the Cancer Commission of the Medical Society of the State of Pennsylvania, the Cancer Committee of the Philadelphia County Medical Society, the Cancer Forum of the Lankenau Hospital Research Institute and quite recently the "Women's Field Army" of the Federated Women's Clubs have united to "Fight Cancer With Knowledge."

Speaking of cancer of the uterus which is my particular concern, I can report that these agencies have accomplished untold good. Forty years ago when I entered upon the practice of medicine, cancer of the uterus was synonymous with a friable bleeding mass or a sloughing funnel or crater. In those days, women paid little attention to an irritating vaginal discharge or to irregular vaginal bleeding. Such symptoms were nothing to bother a doctor about. Women went to the doctor only if they had pain. In other words they went to the doctor too late.

Today, thanks to the campaign of education conducted by various agencies, many women have learned the significance of such apparently trifling symptoms as an irritating vaginal discharge or vaginal bleeding between periods or after the menopause. As a result they present themselves with increasing frequency soon after the onset of such symptoms. Today the diagnosis of cancer of the uterus is a different and a much more difficult matter from what it was forty years ago. Often this diagnosis cannot be made by the naked eye but requires the microscopic examination of a portion of suspected tissue.

These varying findings have led to the classification of cases of cancer of the cervix into four different groups. One accepted classification—that of the late Heinrich Schmitz of Chicago—is as follows:

Group I. Clearly localized carcinoma.

Group II. Extensive invasion of cervix.

Group III. Invasion of the parametrium, uterus not fixed.

Group IV. Fixation of uterus, frozen pelvis, involvement of adjacent organs.

The classification of seventy consecutive cases of cancer of the cervix admitted to the Hospital of the Woman's Medical College from 1928 to 1937 is shown in the accompanying chart, Figure 1.

FIGURE 1

70 CONSECUTIVE CASES OF CANCER OF THE CERVIX		
GRADE	CASES	INCIDENCE
I (8 micro.)	26	36%
II	13	19%
III	24	35%
IV	7	10%

The relation between five year survival in a series of fifty consecutive cases and the stage of disease in which the patient first received treatment is shown in the accompanying chart. Figure 2.

FIGURE 2

50 CONSECUTIVE CASES OF CANCER OF THE CERVIX RELATION BETWEEN 5 YEAR SURVIVAL AND STAGE OF DISEASE			
GRADE	NO. CASES	5 YEAR SURVIVALS	PER CENT
I	26	16	61½
II	9	3	33
III	11	0	0
IV	4	0	0
Total	50	19	38

Since the percentage of five year survivals varies inversely with the stage of the disease in which the patient first receives treatment, the importance of finding these cases in an early stage of the disease is apparent. At first glance it might seem that by continuing and expanding the present educational program, a time would come when every woman in this country would know enough to present herself within a few days or certainly within a few weeks after the onset of an irritating vaginal discharge or of bleeding between periods or after the menopause. Granting that this might be the case, the situation is complicated at this point by the fact, that cancer of the uterus seems to run a symptomless course for a variable period of time. During this symptomless period it is possible for the disease to advance beyond the stage of permanent cure. Eight cases illustrating this fact are shown in the accompanying chart. Figure 3.

FIGURE 3

CANCER OF UTERINE CERVIX
RELATION BETWEEN DURATION OF SYMPTOMS AND STAGE OF DISEASE

CASE NO.	DURATION OF SYMPTOM	GRADE
49965	7 days	III
32751	9 days	II
29951	14 days	II
29236	23 days	III
25132	7 weeks	III
41484	7 weeks	III
40117	8 weeks	III
49426	8 weeks	IV

These facts lead to the conclusion that, valuable as the present educational campaigns are, they do

not go far enough. These facts also lead to the conclusion that the best way to discover cancer of the uterus at its very beginning is by examining women before symptoms appear. In other words, by the method of periodic examination.

Three years ago, my associates and I decided to test the validity of these conclusions. As a result of appeals to many different groups, one thousand well, white women, thirty years of age and over, volunteered to help us solve this problem by coming for pelvic examination twice a year for a period of five years. The Committee on Scientific Research of the American Medical Association gave us financial help to cover the expense of stationery, secretarial service, supplies and the microscopic examination of suspected tissue. The Woman's Medical College of Pennsylvania gave us clinic space and nurses' service. The medical profession of Philadelphia gave us hearty coöperation.

To date 1,000 volunteers have been examined three times. Eight hundred and eighty of these have been examined four times. Many have been examined five times and quite a few have been examined six times. Today, I wish to report on a series of 3,880 examinations.

These examinations consisted in:

1. A careful bimanual examination.
2. A careful inspection of the cervix in a good light.
3. The application of Lugol's solution to the cervix according to the technique of Walter Schiller.
4. A test for friability of tissue according to the technique of Chrobak.

After the first two thousand examinations we gave up the use of the Schiller test, because we felt we were deriving no particular help from it. We found it as easy to detect a white spot on a pink surface as to detect a yellow spot on a brown surface. At first quite a few biopsies were performed. As the experiment proceeded, we were more inclined to recommend the removal of cervical pathology in toto by means of surgery or conization. The entire area was thus available for microscopic examination.

In the first 1,000 examinations, one early cancer of the body of the uterus and three early cancers of the cervix were found. These cancers were treated by means of surgery, radium and x-ray. The volunteers in whom these cancers were discovered return at frequent intervals for examinations. They are well today. No other cancers of the uterus have been found.

In the three thousand nine hundred examinations, forming the basis of this report, in addition to these four early cancers, 516 benign lesions of the pelvic organs were found. Of these 257 come under the generally accepted term of precancerous lesions of the cervix—leukoplakic areas, cervicitis with erosion—simple, papillary or follicular. Of these potentially serious lesions, 119 have received appropriate treatment and the menace of cancer has been removed.

PROCEDURES USED IN TREATMENT OF 119 PRECANCEROUS LESIONS

Cauterization of Cervix	-	-	46
Conization of cervix	-	-	18
Repair of cervix	-	-	12
Amputation of cervix	-	-	6
Sturmdorf trachelectomy	-	-	34
Excision of leukoplakic areas	-	-	3
Total	-	-	119

CONCLUSIONS

Time alone will determine the value of this experiment in the control of cancer of the uterus. At present its value would seem to be threefold. In the first place, the research has led to the discovery of four unsuspected cases of cancer of the uterus in an early and apparently curable stage. In the second place, it has led to the discovery and appropriate treatment of 119 lesions of the cervix which, according to our present knowledge, are believed to predispose to the development of cancer. In the third place, it has sold to 1,000 women of cancer age, to their relatives and to their friends the idea of the importance of periodic pelvic examination.

For those who are conducting the experiment, the periodic pelvic examination of 1,000 supposedly healthy women has proved a most enlightening experience. After inspecting a large number of healthy cervixes—smooth, homogeneous, pale pink in color—diseased cervixes have assumed a significance which they never had before. Mild forms of cervical pathology which previously attracted little attention, are now something to be watched, to be treated or even to be removed because of increasing familiarity with the appearance of the healthy cervix.

The example which has been set at the Woman's Medical College in Philadelphia has been followed in several other cities. I hope my presentation of the subject today may interest some of the group here present to start a similar project in Connecticut.

PHYSICAL STATUS OF AMERICAN YOUNG MEN

G. ST. J. PERROTT, *Washington, D. C.*

The Author. M.A. *University of North Dakota, 1915.*
Chairman of the Health Division of the District of
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WHILE death rates among young men, aged 20-34 years, have declined nearly 30 percent since the World War, results of Selective Service examinations show no improvement in the physical fitness of living young men. About 43 percent of all men examined are being declared unfit for general military service either by local draft boards or at army induction centers. This compares with a figure of about 30 percent rejections in 1917-1918. Among the important causes of rejection are defective teeth (8.3 percent of all men examined), eye defects (5.0 percent), heart diseases (3.7 percent), musculoskeletal defects (3.2 percent), nervous and mental diseases (3.0 percent), ear, nose, and throat diseases (2.4 percent), hernia (2.0 percent), respiratory diseases, largely tuberculosis (1.7 percent), venereal diseases (1.6 percent), foot defects (1.4 percent), underweight (1.4 percent).

Of the 43 percent of men declared unfit for general military service, 32 percent are so classified by the 6,450 local boards and an additional 11 percent at the Army induction centers. This means that out of every 100 men declared physically fit by the local boards, an average of 16 are rejected in the thorough re-examination at the Army induction centers.

While draft board and Army physicians rejected 43 percent of the men for full military service, only 28 percent were considered unfit for any service. The remaining 15 percent were classed as fit for limited service and many of these undoubtedly had defects which were remediable.

The most striking difference between the results of 1917-1918 and today is the present high percentage of rejections because of defective teeth which are over four times as high as in the World War

draft. It should not be concluded that this necessarily indicates an increase in the prevalence of dental disease since 1918. It may indicate that young men today have had less dental care during childhood and adolescence than those of 1918, due perhaps to the effect of the depression. Furthermore, while army standards have not changed since the last war, it is possible that they are being more rigidly enforced today. Other factors may play a part, such as the fact that deferments because of dependents or essential occupation tend to concentrate young men of low economic status who have had inadequate dental care in the group who are certified for physical examinations.

Rejections for respiratory disease (largely tuberculosis) are only a little lower than in the World War (1.7 percent as compared with 2.0 percent). Since mortality from tuberculosis has been cut in half in that time, it would appear that a better case finding job is being done in the present examinations.

Rejections for venereal disease constitute 1.6 percent of men in the present examinations as compared with 0.5 percent in the last draft. This higher percentage need not indicate an increase in the prevalence of venereal disease since 1918 but is probably due to more rigid standards today which exclude men with venereal disease and to the use of better diagnostic methods.

In spite of the higher percentage of rejections reported today than in 1917-1918, it can not be said that the physical status of young men has deteriorated since the World War. Neither can it be said that the health of young men has improved. Differences in physical examination standards, in technique of examining physicians, and other factors make comparison difficult until the data can be analyzed in more detail. Rejections for defective teeth are obviously higher in 1941 than in 1918; otherwise the important causes of rejection today are the same as those in the World War draft.

Recent preliminary results of physical examina-

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Abstract of a paper presented at the Clinical Congress of the Connecticut State Medical Society, September 17, 1941

tions of young men in National Youth Administration projects confirm the results of Selective Service. Nearly 30 percent of N.Y.A. youths aged 21-24 were judged by examining physicians to have physical defects which handicapped them to a greater or less extent for work. To remedy these conditions, physicians recommended eye refractions in 16 percent of the youths examined, tonsillectomy (12 percent), hernia repair (2.4 percent), venereal disease treatment (2.1 percent), hookworm treatment (3.1 percent), and other medical or surgical procedures in a large number of cases. Under the health program being inaugurated by the National Youth

Administration, it is planned to rehabilitate these youths whenever possible.

The correction of defects among youth must be regarded as of importance not only from the point of view of military man power, but also from that of industrial man power and public health generally. Furthermore, over and above the need for remedial care which these figures show is the realization that many of the impairments could have been prevented by more extended public health programs during the period of growth of these individuals. This fact emphasizes the need for further development of such programs in the future.

CARCINOMA OF THE DUODENUM

NORMAN L. CRESSY, M.D.

The hospitals of Connecticut have been invited to furnish one case report from their clinico-pathological or tumor clinics for publication in the JOURNAL. The following from Meriden Hospital (Meriden) is the ninth in the series. (The Editor.)

IN A RECENT extensive review of carcinomas in the region of the papilla of Vater, Lieber, Stewart, and Lund report 222 cases which they classified in the following manner:

- I. Primary carcinoma of the Ampulla of Vater. 1 case.
- II. Primary carcinoma of the terminal duct of Wirsung. 3 cases.
- III. Primary carcinoma of the common bile duct. 7 case.
- IV. Primary carcinoma of the intestinal mucosa covering the papilla of Vater. 3 cases.
- V. Carcinoma involving all epithelial structures in this region. 182 cases.
- VI. Carcinoma involving all of the above mentioned structures except for the mucous membrane of the intestine. 33 cases.

The case herewith presented is an example of a carcinoma of group IV.

CLINICAL HISTORY

F. F., a 59 year old white male factory worker, was seized with a dizzy spell while at work early in the morning. A urine examination by the attending physician showed complete reduction at that time.

He was noticed also to be slightly but definitely jaundiced. He was referred to his family doctor who made a diagnosis of diabetes mellitus and admitted him to Meriden Hospital on the following day. Upon questioning at the time of admission, he denied all signs and symptoms of diabetes. There was no cough, chest pain, weight loss, vomiting, or diarrhea. The past history and family history were not contributory.

PHYSICAL EXAMINATION

The temperature was 103°, the pulse 88, the respirations 24. The blood pressure was 146/84. He appeared a rather thin, slightly jaundiced middle aged man. He was in no evident distress. The heart was regular in rhythm, not enlarged, and there were no murmurs. The lungs were clear to percussion and auscultation. The abdomen was somewhat distended, but it was soft and there was no tenderness. The liver was felt 2 cm. below the costal margin. The remainder of the examination was essentially negative.

COURSE IN HOSPITAL

The temperature taken later on the day of admission was found to be normal. Repeated blood sugar determinations and urine examinations substantiated

the diagnosis of diabetes mellitus. He was placed on protamine zinc insulin which was carried as high as 40 units daily without noticeable effect. His jaundice became deeper rapidly, and on 9/18/40, 5 days after admission and 6 days after jaundice was first noted, the icteric index was reported as over 100, and the urine was positive for urobilin. An intravenous cholecystogram failed to outline the gall bladder. One blood culture was negative. The prothrombin time was 75% of normal on two occasions.

The clinical diagnosis was carcinoma of the head of the pancreas with obstruction of the common bile duct.

On the 12th hospital day, a cholecysto-jejunostomy was performed with an end to side anastomosis of the proximal end of the jejunum to the first loop of the jejunum. It was planned to resect the duodenum and head of the pancreas and to establish a gastroenterostomy at a later date.

At operation a nodule could be felt through the wall of the duodenum which was thought to confirm the preoperative diagnosis.

Following operation, the patient did very poorly. The temperature and pulse rose sharply and signs of bronchopneumonia developed at both lung bases. He died on the fourth postoperative day, 16 days after admission.

POST-MORTEM EXAMINATION

At the time of post-mortem, there was very little jaundice remaining. The pertinent findings were confined to the lungs and duodenum.

The operative anastomoses were found to be in good condition. There was no peritonitis. In the peripapillary portion of the duodenum, there was found a firm papillary mass which measured 3 cm. in length, and 2 cm. in width, and which projected 0.5 cm. above the surrounding typical mucous membrane. It completely surrounded the papilla of Vater. (See Fig. 1.) A probe was easily passed through the opening of the papilla and into the ampulla. On section the mass was found to be firm and gray white in color. The surface was irregularly serrated and atypical tissue appeared to extend into the muscularis. The ampulla was found to be narrowed by compression of the tumor mass, but there was no involvement of the mucous membrane of the ampulla grossly.

Beneath the visceral pleura of the lungs there were numerous scattered gray white nodules. These were

one to two millimeters in diameter and slightly raised above the surface. On section, these were found to be homogeneously gray white and opaque. They extended beneath the surface for a distance of only 1 or 2 mm. In addition, there was atelectasis of the right lower lobe and considerable pneumonic consolidation throughout both lungs.

MICROSCOPIC EXAMINATION

Sections taken from the region of the papilla of Vater reveal the mucosa of the duodenum to be replaced by atypical epithelial cells arranged in sheets and in well differentiated acini. These cells invade the submucosa extensively and extend into the internal muscular layer. The mucosa of the ducts except at the tip of the papilla itself, however, is uninvolved. The individual cells are large and have abundant granular pink staining cytoplasm. The nuclei are large, oval, or round, and contain blue staining granules. There are many mitoses.

Sections of the nodules beneath the pleura mentioned above, reveal groups of atypical epithelial cells similar to those found in the duodenal tumor. Sections from the liver and thoracic duct reveal no metastases in these structures. There were no notable histologic changes in the pancreas.

DISCUSSION

In the analysis presented by Lieber, Stewart, and Lund, the symptoms occurring with acute onset in order of frequency were: jaundice, pain, loss of weight, loss of strength, anorexia, vomiting, fever, nausea, constipation, diarrhea, chills, and a feeling of heaviness in the abdomen. In the group of cases with gradual onset, the symptoms in order of frequency were: pain, anorexia, loss of weight and strength, sense of weight or pressure in the abdomen, jaundice, vomiting and diarrhea.

That this patient did not have more symptoms is not surprising in view of the small size of the lesion. The cause of the jaundice is obvious. The absence of pain can probably be explained by the fact that the growth had extended only into the internal muscular layer and not into the retroperitoneal tissues. In the absence of histopathologic changes in the pancreas, the presence of diabetes in this case must be considered merely coincidental with the duodenal tumor.

The metastases in this case are interesting, particularly in view of the absence of involvement of the local lymph nodes or liver and the presence of



FIG. 1

Carcinoma involving the Peripapillary Portion of the Duodenum. View of Left Half of the Specimen, Stomach at left. The Tumor has been Split Longitudinally through the Papilla revealing the Head of the Pancreas and the Common Bile Duct and Duct of Wirsung Separated terminally by a Septum.

intrapleural metastases. The last mentioned site is rare according to Vaughn, the others relatively common. In the material reviewed by Lieber, Stewart and Lund, 43% of cases with involvement of all epithelial structures in the region of the ampulla showed metastases; where the mucosa of the duodenum was spared only 27% showed metastases.

It is discouraging that this patient who came to operation only 12 days after his first symptom, and

whose tumor was small and easily resectable, already had pulmonary metastases.

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THE BACKGROUND OF PUBLIC HEALTH IN CONNECTICUT

IRA V. HISCOCK

EIGHT YEARS after the founding of Connecticut Colony, on June 3, 1644, the town clerks or registrars in the several towns were ordered to keep a record of every person "Hereafter marrid wthin their libertyes, and of the day of the birth of every child hereafter borne." This system of registration, the first reference of public health significance in the colonial records, was extended by the general court in 1650 to include deaths, with provision for ultimate central registration at Hartford.

Health legislation of Colonial Connecticut was directed primarily against the spread of smallpox, a disease which today is a medical curiosity in this State. Between 1663 and 1756, legislation was concerned with quarantine, and from 1760 to 1771 with the practice of inoculation. Except for the control of epidemic disease (especially smallpox), the subject of public health was unrecognized by the legislative and executive authorities. It should be remembered that the great sanitary awakening came in the first half of the nineteenth century, and that Pasteur's brilliant series of investigations, which helped to give a scientific basis of prevention, began in 1858.

The earliest settlers experienced a variety of illnesses. During the first year of the settlement called Quinnipiac—later named New Haven—in December, 1638, a general fast was kept—"The chief occasion was the much sickness of pox and fevers spread through the country, (yet it was to the east and south also)." Three years later there was prevalent a peculiar worm disease believed to be due to worm-infected corn. Noah Webster wrote concerning the year 1647: "This year appeared an epidemic catarrh in America, and the first of which we have any account. It is not named either influenza or catarrh, but is clearly the same disease."

Provision of medical care for the sick and injured early engaged the attention of legislators. Thomas Lord was apparently the first practitioner licensed by the general court held in Hartford in 1652, although Thomas Pell was the pioneer physician of the State, (serving as military surgeon at the Saybrook fort and in the expedition against the Pequots in 1637); later sharing with Nicholas Augur the responsibilities in New Haven. While Pell was a lawyer and trader as well as a physician, Augur's main source of income was from his medical activities, and he encountered difficulties in the collection of fees. On one occasion:

" . . . he hath given phisicke to Mr. Malbon's servants. . . . and something to a mare that was bitten with a rattel snake; and that ther is due to him for it 44s 10d: he desires the Court would afforde

him some help that he might be paid." And later the governor declared "That Mr. Augur had been with him, and informed him of his intentions to lay downe the practise of physicke, because his pay is not brought in in season for what he hath done, wch was witnessed against as an act of unrighteousness; those wch were faulty herein were desired to attend their duty; that the discouragements may be removed from Mr. Augur." A later record, ". . . his stocke of phisicke is gone, and how to procure more out of his retournes he saw not, being disabled by the non paymt of some and ye unsutable paymt of others to get supplies. . . ."

Augur was interested in sanitary nuisances and in 1662 "propounded to the Towne for liberty to make a passage (for ye water) downe the streete. . . . it being very affecting and exercising to them at some seasons . . ."

In 1654 an epidemic of smallpox raged so severely that the Connecticut legislature appointed a day of general fast, one reason for which was—"the mortality which had been among the people of Massachusetts and Connecticut." The following year there was "another faint cough that passed through the whole country of New England, occasioned by some strange distemper or infection of the air. It was so epidemical that few persons escaped. It began about the end of June. Few were able to visit their friends or perform the last testimony of respect to any of their relations at a distance.

Influenza, diphtheria, measles and pneumonia, in virulent form, raged through the colony from time to time. But smallpox stimulated unusual action. Massachusetts instituted a quarantine against ships from the Barbadoes in 1647. In Connecticut, action by the general assembly of 1663 was aimed at the exclusion of infection from New York. Three years later the problem of maritime quarantine was referred to local authorities "in accordance with the cherished Connecticut principle of local self-government." The last two decades of the seventeenth century were marked by a heavy incidence of disease, according to references in Thanksgiving proclamations and to notes of the inability of the general court to meet on certain occasions on this account. Following a period of emergency legislation, the general assembly of 1702 passed the first comprehensive act for maritime quarantine.

Early legislation relating to foods was of a commercial rather than health nature; and also lacked provisions for general sanitation. However, following action of the general assembly in 1711 for the appointing of commissioners of sewers to provide for the draining or flowing of swamp lands, there may have been important effects upon malaria which constituted a great health problem of the colony.

A severe outbreak of an unknown disease recorded for Waterbury for October, 1712 . . . "raged for eleven months. It was so general, that nurses could scarcely be found to tend the sick. What the disease was, I am not informed; but not improbably it was the species of putrid pleurisy, which has so often made dreadful havoc in America." Measles was prevalent in 1713, and during the next seven years "raged a malignant pleurisy in Hartford especially" but also in New Haven with great mortality.

The spread of smallpox by peddlers and chapmen was dealt with by an act of 1721 which forbade "the trade of carrying goods from town to town or from house to house" under penalty of a fine of 10 pounds without right of appeal or review. In 1728, the general assembly amended the quarantine act:

"Be it enacted and ordained by the Governor, Council and Representatives, in General Court assembled, and by the authority of the same. That when it shall happen, by reason of any infections or other disease, that it shall become necessary in the judgment of the selectmen of the town that tenders should be impressed into that service, and a warrant is accordingly granted, and any person or persons impress'd, that upon his or their refusal or neglect to attend the said service, that it shall be in the power of them who granted the warrant, if sufficient cause of excuse to them satisfying be not shewn, to commit him, her or them, to the common goal of the county where it happens to be, there to remain at his, her or their charge, till they will better conform themselves, or the occasion of the impressing shall be over and signified by them who granted the warrant to the keeper of the goal under their hands."

In 1732, a new and elaborate quarantine act was passed, chiefly a restatement of previous acts, providing for isolation, quarantine and care of the sick. In that year a severe catarrh, quite fatal for adults, broke out; children were also ill with a fatal "distemper," or the "plague of children" in New England, with a heavy incidence in parts of Connecticut. This was followed a few years later by an outbreak of "ulcerous sore throat" (diphtheria), and by a general attack of influenza.

In 1745 Stamford experienced a severe attack of dysentery "which swept away seventh inhabitants out of a few hundreds." Four years later dysentery and "nervous lung fever" visited many towns with high mortality, followed the next few years by measles and by malaria. "At Bethlehem in Connecticut raged a mortal fever, which swept away between thirty and forty of the inhabitants."

During 1769 mention is frequently made of the incidence of rabies and of epidemic and fatal dysentery. Measles was prevalent until 1773 when it was supplanted by the "cynauche trachealis" or "bladder in the throat." A severe dysentery was described as "of a peculiarly malignant type, occasioning mortification on the third day." The "cynanche maligna" was prevalent and severe in 1775. Influenza struck again in 1781 and in 1789. Then "scarlatina" occurred in virulent form.

Meanwhile, attention was given to problems of quackery, and an act relating to public health, passed in 1773, deals with the question in the following terms:

"Whereas the practice of mountebanks in dealing out and administering physick and medicine of unknown composition indiscriminately to any persons whom they can by fair words induce to purchase and receive them without duly consulting, or opportunity of duly consulting, and considering the nature and symptoms

of the disorder for which, and the constitution and circumstances of the patient or receiver to whom they administer, has a tendency to injure and destroy the health, constitution and lives of those who receive and use such medicines: And whereas the practice of mountebanks in publicly advertising and giving notice of their skill and ability to cure diseases, and the erecting publick stages and places from whence to declaim to and harrangue the people on the virtue and efficacy of their medicines, or to exhibit by themselves or their dependants any plays, tricks, juggling, or unprofitable feats of uncommon dexterity and agility of body, tends to draw together great numbers of people, to the corruption of manners, promoting of idleness, and the detriment of good order and religion, as well as to tempt and ensnare them to purchase such unwholesome and oftentimes dangerous drugs:

Be it therefore enacted by the Governor, Council and Representatives, in General Court assembled, and by the authority of the same, That no mountebank, or person whatsoever under him, shall exhibit or cause to be exhibited on any publick stage or place whatsoever within this Colony, any games, tricks, plays, juggling or feats of uncommon dexterity and agility of body, tending to no good and useful purposes, but tending to collect together numbers of spectators, and gratify vain or useless curiosity. Nor shall any mountebank, or person whatsoever under him, at or on any such stage or place offer, vend or otherwise dispose of, or invite any persons so collected to purchase or receive any physick, drugs or medicines, commended to be efficacious and useful in various disorders."

Of much importance to public health was the establishment, January 5, 1784, of the Medical Society of New Haven County, the second oldest medical organization in this country. The purposes of the society were stated as follows:

"1. To bring the physicians closer together by increased friendship, and by giving them an esprit de corps.

2. To study various climatic conditions and their effects on general health, with mode of treatment for the ill-effects so caused.

3. To enable inter-communication with other groups, of knowledge obtained in the fields of medicine, surgery, botany, or chemistry.

4. To correspond with neighboring medical societies either in this country or in Europe.

5. To join with the several other medical societies within the State in application to the Legislature 'to adopt such measures for the future regulation of our Salutary Art, as shall effectually support and countenance Merit, and discontenance ignorance and Presumption.' "

From the very beginning the Society was interested in the prevalence of

diseases and in measures for their control. As early as October 1, 1788, it was decided ". . . that the Reverend, the Clergy of the County of New Haven be desired to give us a quarterly list of deaths in their several societies, with the disease." The Society for a time carried the task of recording births, deaths and marriages.

Yellow fever occurred in Connecticut in the latter part of the seventeenth century, but did not attain a prominence comparable to smallpox which terrified both physicians and the general public. With influenza, scarlet fever, and diphtheria also falling heavily, "the bilious plague" appeared in New Haven on June 10, 1794. This case of yellow fever was not correctly diagnosed until shortly before the patient's death on the 15th, and because of the widespread incidence of other virulent diseases, the picture was somewhat confused, delaying realization of the impending new epidemic. As new cases appeared and the contagious nature became apparent, the town was thrown into a panic; we are told that, "At 4 P. M. inhabitants assembled at the New Meeting House to unite in prayer and supplication to God on account of the sickness . . ."; later the inhabitants requested the selectmen to make a careful examination and inquiry into the origin and character of the disease.

But while the request for study was simply stated, scientific knowledge of the cause and mode of spread of yellow fever was lacking. People had a vague idea that the origin of yellow fever and of most of the other fevers was in the West Indies. If no direct contagion could be demonstrated, reliance was placed on the common pythogenic theory of the association of epidemic fevers with putrefaction of filth. Conflicting ideas were advanced. At the time of the epidemic, some believed that the fever originated from a trunk belonging to a sailor who had died of yellow fever. This trunk had been placed in a Mr. Austin's store, opened, and carefully examined by him and the captain of the vessel in the presence of Henry Hubbard and Polly Gorham; all but the captain later became ill and died of the disease. Doctor Eneas Munson cited his viewpoint as follows: "The yellow fever was attended with specific infection in every instance, and proved equally mortal in every part of town, in proportion to the number that were sick. No age nor sex was exempted from its ravages; all descriptions of people were alike susceptible of receiving infection . . . I could trace the disease throughout the town. No person had yellow fever, unless in consequence of attending the sick, or of being exposed by nurses, infected houses, clothing, or furniture." But Doctor Stiles wrote: "Hitherto I have believed that by the care and vigilance of the authorities, it might be guarded and its progress checked, as we could hitherto, trace all the instances; but now they begin to be lost and bewildered. I begin to give up the possibility of preventing its spread, and to be discouraged and to wish my family out of town." Webster's theory was that the attack was caused by the "epidemic constitution of the Atmosphere."

The conquest of yellow fever represents perhaps the most dramatic episode in public health. Between the years 1702 and 1800 this terrible disease appeared in the United States thirty-five times and between 1800 and 1879

it visited this country every year with but two exceptions. In 1793 a tenth of the population of Philadelphia are said to have perished from its ravages. Matthew Carey in his account of this epidemic says, "it is not probable that London, at the last stage of the plague, exhibited stronger marks of terror than were to be seen in Philadelphia from the 24th or 25th of August till pretty late in September." For over a century more the etiology of this disease remained obscure, until the experiments in 1900 of a commission of United States Army officers in Havana proved that yellow fever was transmitted by the bite of a certain mosquito, paving the way for extensive mosquito control measures throughout the world. Within the past decade immunization measures against this disease have been developed by the Rockefeller Foundation.

Somewhat as the Black Death in England crystallized the beginning of the conception of health conservation, this yellow fever epidemic in New Haven gave cause to study the nature of the disease, and, if possible, what means might be discovered for prevention and cure. From the confusion which obviously existed even previous to the epidemic of yellow fever, there was formed, of necessity, a health committee, appointed by the town selectmen, which had as its principal duty the recording of the progress of the disease, investigation of the reported sick, elimination of sources of filth, correspondence with neighboring cities regarding the status of health and disease, and coöperation with physicians. This committee was a forerunner of the first local Board of Health.

Several references have been made to Noah Webster (1758-1843), a member of the health committee and of the first Board of Health in Connecticut. Born in West Hartford, as was also the distinguished pioneer in public health William Thompson Sedgwick (1855-1921), Webster wrote upon many scientific problems, particularly during his sojourn in New York and his first residence in New Haven. Warthin says:

"Nothing affecting the life of the American people during this time escaped his interest and active attention. Their language, education, politics, political economy, morals, religion, laws, vital statistics, agriculture and general culture all received treatment at his hands."

In commenting on Webster's diary, the same author states:

"It was but natural that in the earlier years of this diary the ladies formed a not inconsiderable portion of the material of his observations; but after he achieved marriage, they gave place to comets, meteors, floods, and storms, so that his journal becomes largely meteorological in character."

Three subjects chiefly held Webster's attention in the last decade of the eighteenth century and the first decade of the nineteenth—meteorology, vital statistics, and epidemiology. While he was deeply interested in vital statistics, his chief contribution to the natural sciences was his study of epidemiology, particularly of the epidemiology of yellow fever. Representative of the age in which he lived, his theories may be called inadequate and

his methods of analysis essentially unsound. But Noah Webster was ahead of his age in the accumulation of data—"essential as raw material for the building of the modern edifice of epidemiology.

From March 17, 1806, the records of activities of the New Haven Board of Health were carefully maintained. Henry Daggett and Elisha Munson, prominent physicians, were elected President and Clerk, respectively; Noah Webster and Isaac Tomlinson were selected "to fix the landmarks and boundaries of the quarantine ground; Elizur Goodrich, Simeon Baldwin, and John Barker were appointed a committee to devise a general scheme of regulations under the law—'providing in case of Sickness.' " Three days later the Board stated "That if any person shall violate the provisions of the laws 'providing in case of Sickness' the penalties will be most rigorously enforced upon such delinquent." The Board also voted that: (1) a standing committee, the "Health Committee," consisting of five members, should be annually appointed, and outlined the duties of the committee; (2) ". . . an agent or attorney shall be annually appointed in the month of March with whom the Health Committee may consult—whose duty it shall be to pursue and prosecute all actions, which the Board of Health Committee shall direct to be instituted;" and (3) a health officer be chosen annually. Simeon Baldwin was the first attorney selected by the Board of Health; and Doctor John Barker was chosen the first health officer, whose duties were chiefly to inspect incoming vessels.

On the 14th of July, 1819, a regulation was passed which had a direct bearing on the relationship between the Board of Health and the physicians:

"To the physicians of New Haven—

In pursuance of the 16th section of the Act in addition to and in alteration of the Act entitled 'An Act providing in Case of Sickness' you are hereby requested by the Board of Health for the town of New Haven to make a daily report to said Board at my Office in New Haven of such cases of pestilential or malignant fever or disease as occur in your practice, respectively specifying each patient's name and place of residence, on penalty of the law."

In January, 1824, the Board of Health voted ". . . that the Selectmen of the Town be a Committee to superintend the inoculation of the citizens with the kine pox, and for that purpose to make such a contract or contracts with such of the practicing physicians as they shall judge proper, for the purpose of effecting the object." It was soon decided to make a contract with physicians to vaccinate all the citizens of the town who had not yet had the disease or had not been vaccinated—"provided the same can be effected for the sum of one hundred and fifty follars . . . and if said Committee cannot contract with the practicing physicians of the Town or any part of them for said sum, then and in that case said Committee may make a contract with some other Physicians or person to do the same on the terms aforesaid, and all at the expense of the Town."

A few years later when a case of "varioid smallpox" in Yale College was discovered, the College immediately arranged to have the "Wallace

House" used as an isolation hospital, and the plan was submitted to the Board of Health for approval. The arrangement was regarded as satisfactory "provided that the various roads and avenues leading to said Wallace House be fenced up, and at the expense of the Faculty, and it is ordered that no person or persons except the Nurse and attending Physicians be allowed to go to, or to enter said Wallace House."

In June, 1832, the Medical Association of the City of New Haven became concerned over the sudden occurrence of several cases of Asiatic cholera in New York, and appointed a committee of four physicians, acquainted with physicians who had treated earlier cases of cholera, to appear before the Board of Health to offer their advice and to make a few pertinent suggestions. They asked the Board of Health for their coöperation in endeavoring "to prevent this Malady, or to arrest or mitigate it" The Board responded by placing one member of the Association's Committee—Doctor Charles Hooker—on the standing Health Committee which was empowered to put into effect all recommendations offered by the Association for the prevention of the introduction of the disease. Noah Webster was later appointed to serve on a new nuisance committee which aimed to rid the city of cholera foci. Citizens, asked as a body to search their homes for sources of filth or putrefying material, became unusually stimulated, and many sent petitions to the Board of Health dealing with a variety of ideas and requests, resulting in statements from the Board giving assurance "that every precaution in their power has been and will continue to be used, to protect the city from cholera."

Much energy was expended during these years on matters of cleanliness, sanitation and housing; while measures to combat communicable disease, with only limited knowledge of sources and modes of infection, were continued. It may be recalled that the first phase of the modern movement for public health was a period of environmental sanitation, which extended roughly from 1840 to 1890, receiving much of its early impetus in England. A period of scientific control of communicable disease by the applications of bacteriology dominated the field between 1890 and 1910. Then followed periods of emphasis on the education of the individual in the practices of personal hygiene, and on the importance of organization of community machinery for the early diagnosis and preventive treatment of disease. The social aspects of medicine and public health are now receiving increased attention.

The early and continuing coöperation between the New Haven Medical Association and the New Haven Board of Health was significant. It is also noteworthy that in the last half of the nineteenth century was passed a resolution by the Medical Association "That the Selectmen be respectfully requested by the New Haven Medical Association to select their candidate for the office of Registrar of Births, etc., from among the members of this Associations." The value of having the registration and analysis of vital statistics under the direction of a physician, and also as a function of the health department, has been demonstrated in the city of Hartford, where Doctor Charles P. Botsford, long health officer of that city, developed and

maintained admirable records for the guidance of the public health program, as did his neighbor, the late Doctor Charles V. Chapin, long Superintendent of Health of Providence, Rhode Island.

When local boards of health had been established in 1805-1806, it was ordered by the general assembly, that "The civil authority and the selectmen in the several towns shall be a Board of Health, in their respective towns, with authority now, not only to prevent the spread of contagion, but also to protect the public from other causes of disease." They were empowered to examine into all nuisances, and such sources of filth as might be injurious to health. This law remained in effect until 1875 when it was amended by giving permission "to add physicians of good reputation to its Board." An amendment in 1872 to the original charter of the city of New Haven, the first town to appoint such a Board of Health, marked an important step forward and preceded the state-wide change.

A gradually changing viewpoint concerning the scope and significance of public health sixty-seven years ago is reflected in a statement of the Health Officer of New Haven (soon to become a member of the first State Board of Health), Doctor Charles A. Lindsley in his annual report for 1874:

"We are not content ourselves with merely playing the role of a nuisance committee, abating the petty contentions of neighbors about privies and pigstyes. But our responsibilities cover a far broader, more extended and comprehensive field.

"When the public comes to comprehend our true official character, as in time they will, we shall be expected not only to supervise and, when possible, direct in matters affecting public health, but also to become a source of information in regard to all questions of public hygiene. We are to know and be able to inform and advise in regard to everything connected with the physical well being of our fellow citizens."

The general assembly in the January session of 1878 passed an act establishing a State Board of Health. This was thirty years after the organization of a general Board of Health in England, twenty-eight years after the Report of the Massachusetts Sanitary Commission, (a document drafted by Lemuel Shattuck which drew its inspiration from Edwin Chadwick and Sir John Simon of England and is regarded as the beginning of the public health movement in the United States), and nine years after the establishment in Massachusetts of the first State Board of Health.

The first annual report of this Board, suggesting plans and problems, also reproduced a circular, sent to every clergyman in the State, outlining the work of the Board of Health and discussing public hygiene. "The appeal to the clergy was rendered appropriate, too, from their position as public instructors, since they as a class are among the most public-spirited of our citizens, and from the nature of their work come into close relations with all classes of society."

Up to 1915 the major services of the State Board of Health consisted of vital statistics registration, laboratory work, and limited communicable

disease control activities. When the Board was organized, the office was located on the third floor of the Capitol with the late Doctor Charles W. Chamberlain of Hartford as Secretary. After his death the office was moved to the residence of his successor, Doctor C. A. Lindsley, in New Haven where it remained for twenty-two years, the work growing and expanding. In 1897 there was begun the collection of all records of births, marriages and deaths in the State, together with the monthly reports of communicable diseases by the town health officers. Some of the members of the Board and many state officials had realized for some time that so important a state bureau should have a more permanent location and should be at the Capitol with other state departments. The office was moved back to Hartford in 1906. For the early development of vital statistics in the state, much credit is due Doctor C. A. Lindsley, his able successor Doctor Joseph H. Townsend, and Professor William H. Brewer who for many years served as President of the Board.

In his account of the early years of bacteriology, Doctor Charles J. Foote states that the bacteriological laboratory of the Yale Medical School was started primarily as a hygienic laboratory to do work, particularly water analysis, for the Connecticut State Board of Health. An appropriation was obtained from the Legislature in 1887 to investigate and report on the pollution of the water supplies of Connecticut. "The laboratory had maintained a feeble and dormant existence for a year or two before this time, and the appropriation infused it with new life. When the appropriation was secured, the Board of Health consulted Doctor T. Mitchell Prudden about how best to use it. He told the Board that they should have a bacteriological laboratory of their own with a paid bacteriologist, but failing this they should work in connection with some college. Doctor C. A. Lindsley was at that time Secretary of the State Board of Health and also Lecturer on Medicine at the Yale Medical School; it was natural, therefore, that the work of the Board should be done in the laboratory of the Yale Medical School." As pointed out by Doctor Foote, who was a pioneer in this laboratory service, Doctor Lindsley and Professor Brewer showed the need for a bacteriological laboratory; Doctor Herbert E. Smith, Doctor Samuel Williston and Doctor Thomas G. Lee laid the groundwork for providing a good water supply for New Haven; and Doctor Charles J. Bartlett helped to secure a safe milk supply, as well as serving as the Director of the State Department of Health Laboratories and as a commissioner of the New Haven Board of Health for many years.

In 1905, the laboratories of the State Board of Health were established at Wesleyan University under the direction of Professor Herbert W. Conn who served as director until his death in 1916. While devoting much of his time to biology, Professor Conn also gained distinction for his contributions to dairy bacteriology, and for his investigations of an outbreak of typhoid fever which proved to be one of the pioneer classics in epidemiology. The possibility of infection by raw oysters grown in sewage-polluted waters was recognized, but little emphasized before 1894, when the attention of the world was drawn to the subject by an epidemic of typhoid fever among

students who had attended fraternity banquets on the 12th of October, and had there eaten raw oysters which were afterward proved to have been derived from sewage-polluted oyster-beds. There were 25 cases with 4 deaths. About one quarter of those attending the dinners at which the oysters were served were made ill. In one fraternity house where the oysters were cooked, no cases occurred. Of this epidemic, Professor Conn wrote:

"A more typical example of an outbreak of typhoid due to a single source of infection has hardly been found in the history of medicine, and the example furnishes a demonstration of a new source of danger for this disease.

"The use of raw oysters has before been suggested as a possible source of the spread of the disease. The readiness with which these absorb water, and the fact that they not infrequently lie in positions where contamination with sewage appears to be possible, has led to their being suspected in several cases. It has hitherto, however, not been possible to trace any distinct epidemic to them with anything like demonstrative evidence. The conditions which have occurred at Wesleyan have, however, been exceptionally well adapted to point out this connection. Indeed, if one had planned beforehand a series of experiments designed to prove the possibility of oysters as distributing typhoid, it would hardly have been possible to have devised a more satisfactory series of conditions than those which have obtained in this outbreak at Wesleyan."

In view of the completeness of records of the development of public health in recent years, only brief reference will be made to a few landmarks. In 1897, Willard M. Bryant and Bert W. Chapman organized in Hartford the first company to sell pasteurized milk and cream in the State. This was shortly after Nathan Straus introduced pasteurized milk in baby milk stations in New York. In 1900, the first public health nursing association in the State was established in Middletown, (fifteen years after the first organization of this kind in the country at Buffalo, and twenty-seven years after the establishment at the New Haven Hospital of one of the three first training schools for nurses in the country), followed during the next five years by associations in Hartford, Waterbury, New Haven, Derby, New Britain and Naugatuck. Connecticut is the birthplace of the movement for mental hygiene in the world, the Connecticut Society for Mental Hygiene having been organized in 1908 through efforts of Clifford Beers. The Bureau of Mental Hygiene in the State Department of Health, the first of its kind in the country, was established in 1920. In 1909, in Lampson Hall, Yale University, the American Association for the Study and Prevention of Infant Mortality was organized, three years before the establishment of the Children's Bureau of the U. S. Department of Labor, and one year after the organization of the first Division of Child Hygiene in the New York City Department of Health. Connecticut was the first state to pass a premarital blood test law in 1935 (introduced two years earlier through initiative of officials in Middletown); 26 states now have such a law requiring the examination of both partners before marriage.

Stimulated by the report of the Reorganization Commission of 1915, a major step was taken in 1917 with the reorganization, by action of the general assembly, of the State Board of Health and the establishment of the Public Health Council and the Department of Health, with Doctor John T. Black as Commissioner, succeeded in 1922 by Doctor Stanley H. Osborn. In 1931, the scope of the department was broadened to "maintain laboratories and bureaus of vital statistics, preventable diseases, sanitary engineering, child hygiene, public health nursing, public health instruction, venereal diseases, mental hygiene and occupational diseases." The major activities of the Connecticut State Department of Health are described in a department bulletin published in 1940.

The progress of public health in Connecticut has been gradual but steady in conformity with careful planning by leaders officially placed in responsible positions of community or state, alert to utilize scientific discoveries and tested experiences, and (with relative freedom from partisan politics or desire for self aggrandizement) supported by appropriate legislation, by conservative financial appropriations, and by generally favorable public opinion, resulting in a record of disease prevention and health promotion unsurpassed by any state in the Union. Over the years, the voluntary agencies, including the medical and dental societies, have played a stimulating part in coöperating with the public agencies, in rendering advisory assistance, and in supplementing services which the public agencies were not equipped to render. Scientific research, epidemiology, administrative and educational methods, and training of personnel have been well promoted in Connecticut with a growing recognition of the broad scope and significance of public health.

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MAX MAILHOUSE

OLDEST MEMBER OF THE SOCIETY DIES

Doctor Max Mailhouse of New Haven, who had been a member of The Connecticut State Medical Society longer than any other, died on October 19. Doctor Mailhouse was born in New Haven on February 5, 1857, received his PH.B. from Yale in 1876, and his M.D. in 1878, during his second year in medical school he was a gratuitous student on nomination from the State Medical Society. He became a member of the New Haven County Medical Association and The Connecticut State Medical Society in 1878.

Throughout his membership of more than sixty years, Doctor Mailhouse was an alert and generous contributor to the affairs of the Society. He was an important member of the committee that planned the Centennial Celebration in 1892 and served on many other committees. Medical legislation was continuously a source of interest to him and he was one of the active workers for the passage of the statutes requiring state examinations and licenses for physicians.

Doctor Mailhouse was the President of the Society in 1915-16.

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EDITORIALS

The Small Dust of the Balance

While editorial brows are frowning upon the increased rejections of the present draft over that of 1917-18, it is well for us to consider the broader sociological implications of the problem. Call it what you will, an intervention of kindly fate or favor of a benign Providence, we in these United States of America enjoyed a quarter century of freedom. Ours has been a freedom of choice—where we should live, what we should purchase, what we should eat and where we should travel. Materialistic? Yes. Selfish? Undoubtedly.

Ironically enough, in a land of surpluses with depths of resources both physical and scientific as yet unplumbed, much of our youth has grown up impoverished. However, the figures of the draft rejection* should not be offered as an inflexible proof that the health or the longevity of the people have suffered a reversal in these recent years. The contrary is true, but it must be recognized that hand in hand with the proposed rehabilitation plans there must be a concerted program of health education.

Such a program would compel individuals to live consciously and to act positively in order to help eradicate preventable diseases, and to recognize as well the importance of the nutritional alphabet from childhood to senescence.

We must more strongly than ever hold to the conviction that this country is a nation of men, that it consists basically not of hard steel or mechanical robots, but of individuals every one of whom is entitled to an opportunity for good health. If we continue to learn only by the hard method of emergency we are in truth deserving of nothing better than to be "counted as the small dust of the balance."[†]

The Patient's Dilemma

The problem of the patient in the hospital is becoming daily more involved and more acute. A glance over reports from the various hospitals in the State shows a similar situation existing in each, a shortage of nurses and a scarcity of help for the ordinary tasks which abound in the larger institutions.

*See Page 817, Physical Status of American Young Men, G. St. J. Perrott.

[†]Isaiah 40:15.

Connecticut's defense contracts for the year ending July 31, 1941, amounted to \$748,794,000 being surpassed in New England only by Massachusetts. Considering the United States as a whole Connecticut ranks ninth in defense contracts placed.

The problem of nursing can and should be met in time by increasing the supply and by relieving the staff nurse of many of her tasks which might well be performed by ward helpers. To secure the latter costs money in this day of rising wages but the cost of one ward helper is little compared to one nurse, properly trained and registered.

Everyone appreciates the fact that the daily hospital roster has mounted rapidly since prepaid hospital service became effective in this State, and that it has mounted even more rapidly with the influx of thousands of defense workers. Yet, with all this increase in load, the underlying reason for the hospital, viz., the patient, seems to be very nearly forgotten. The private patient no longer enjoys a room alone. He is often left to his own devices, many times to his own discomfort. He is paying for service and service he should have. It should not be said of any hospital that for a price well within the range of hospital charges a person can get better accommodation, food, service, and general amenities in a first class hotel than he can in a hospital. And being sick he must be fussy and therefore requires more consideration, more comfort than he needs in a hotel. Unless he is able to hire a private staff to look after him he gets less attention, fewer comforts, poorer service than he would in a hotel for the same expense.

Miles Atkinson* has offered one solution to the problem. He suggests that hospitals might make more use of men trained in hotel work. There is a vast difference between the trained hotel man and the casual desk clerk. A few hospitals have adopted this innovation and find not only that their patients praise them but also that they are actually making money. If hospitals can improve their income and in some instances realize a balance on the right side of the ledger, there is no excuse for not employing behind the front office desk, in the housekeeping department, over the kitchen, and even as assistant to the superintendent individuals trained and experienced in hotel work.

The other solution to the present dilemma would diminish the inpatient bed enrollment by establishing and operating a complete outpatient department,

therapeutic as well as diagnostic. To successfully maintain such a department a careful economic basis for admission must be set up and adhered to and the full coöperation of the medical staff must be realized. Whether or not diagnosis and treatment are to be free or performed on a basis similar to ward rates must be carefully determined. To the outpatient department should go many patients who are now occupying beds in the open wards of the hospital. They are referred by their physicians for diagnosis and care by medical experts but these procedures might well be carried out without actual hospitalization. Far more is expected of the family physician now than twenty five years ago and many are unable to keep abreast of the times in every branch of medicine. Some place for diagnosis and often for treatment such as the hospital outpatient department has become a necessity, both for the physician and for the patient. Because it is the patient who must come first, the hospital is being forced to make necessary adjustments.

Socialized Osteopathy

Abraham Epstein of New York, Secretary of the American Association for Social Security, the expert from out of town who appeared before the Judiciary Committee of the Connecticut Legislature advocating the passage of the Bingham Health Insurance Bill, has now turned to the osteopaths for support.

Speaking before two hundred members of the New York State Osteopathic Society, Mr. Epstein declared "it is fortunate that the leadership of the New York State Osteopathic Society has had the vision still lacking in the New York State Medical Society to realize that constructive programs of social action along the lines of providing medical care can only help the physician as well as the nation." It would have been well if Mr. Epstein had been a little more familiar with the fine far seeing social program that has been carried on by the Medical Society of the State of New York for many years. We pause to ask Mr. Epstein what his new found friends, the osteopaths, have done in the State of New York in tuberculosis and cancer and in good medical practice laws?

This champion of the health of the country went further to say at the osteopathic convention, "As *physicians*, you well know the cost of this negligence and the rate of military rejections of our best manhood because of physical unfitness which is

*Atlantic Monthly, August 1941.

higher today than even in 1917 has stunned the nation."

The health insurance bill that Mr. Epstein is advocating, which is now before Congress, would allow an insured person to choose either a doctor of medicine or an osteopath to take care of him in the publicly supported scheme for medical service.

The 17th Clinical Congress Excels

Registration and attendance at the Clinical Congress was again record breaking. When the registration at the 1940 Congress reached 700 it was the unanimous opinion of the committee that the Congress had reached its saturation point and that we would never have such a large registration again. However, in the midst of the turmoil at the registration desk, it soon began to become apparent that 1941 was to be another big year and when the Congress was over the registration had reached 758, a new high mark. Whether this will ever be surpassed no one can say but in the light of what has happened before it would be a bold prognosticator who would say that we had reached the saturation point.

The meeting hall was comfortably filled at all times and it may truly be said that more people heard more lectures this year than ever before and it is hoped that more knowledge was gained.

The caliber of the program has maintained its high level for many years and although some changes are contemplated for next year it is the feeling of the committee that these changes are only corrections of mistakes in the past. The Congress is definitely an important part of the medical life of the profession in and around Connecticut and the earnest efforts of the committee to maintain its high standard are because of their desire to have it remain so.

The New Zealand Experiment

A recent editorial in the *New York Times* would have us believe that medical care in New Zealand has reached Utopian heights. After three years of sparring between organized medicine and a labor government, the latter has set up a social security program to include free medical care. Free medical care—nomenclature to catch the unwary idealist in its pitfalls!

According to the *Times* the cost of the plan is to be the equivalent of \$5,000,000 a year, the source of income to be derived from the social security funds. The standard of fees for the doctors was at first

incredibly low (the equivalent of \$1.00 and \$1.25 per office and house call, respectively) but was raised slightly to appease the righteous indignation of the profession. These fees are to constitute full payment to the physician and he, in return, is expected to give the best in service to the needy.

Following the above announcement on September 7, the *New York Times* editorialized as follows:

"Though the bill may be modified as the result of the doctors' storm of protest, New Zealand's example (free doctor care) should be taken to heart . . . But if we are not to go at least part way down the road that New Zealand is evidently bent on following we shall need to have a practical alternative. Organized medicine itself can, and should provide that alternative by advocating a policy which will recognize the necessity of a sweeping change in the pattern of medical practice, make the hospital the center of every community's medical activities, bring the best that medicine has to offer to the needy, and permit the public to organize its own medical services under competent supervision."

In assuming this position the *Times*, theoretically, would bring about a "sweeping change in the pattern of medical practice." It would cast into the discard all that has been learned by actual experience, and would rearrange the community with the hospital as its central point. The Westchester Medical Bulletin states ironically, "it is really just a matter of slogans, newspaper and magazine campaigns, reversing the practices of a profession . . ."* In reality the matter cannot be dismissed so readily. At present the Social Security program in this country has not reached the successful point where free medical care would be other than a burden, consequently medical care would be neither free nor of the highest medical standards. The physicians of New Zealand may have been coerced into a plan for medical care, but let it not be the aim of the sponsors of more social security in this country to saddle our people with any similar costly and idealistic scheme. Any change in the present plan of medical care should be the result of careful study and not of the demands of the social reformer. To renounce the control of medical care to a political bureaucracy would not improve the situation or solve the problem. Organized medicine is seriously attempting to provide what the *Times* designates as "a practical alternative." It differs radically with this exponent of social reform, however, in the method of attaining such an alternative.

*Westchester Med. Bull., Oct. 1941.

Frank Burr Mallory

The death of Doctor Frank Burr Mallory on September 27 removed from the field of pathology one of the most outstanding morphologists and teachers of our time. Doctor Mallory was a man of great scientific attainment as well as of rare "human qualities" and his achievements demand high tribute.

His primary interest was the laboratory of pathology, and here his abundant faculties in technical procedure and morphological analysis reached full expression. His "Pathological Technique" and "Principles of Pathologic Histology" have been the morphologists' *vade mecum* since their publication more than 40 years ago; they still remain standard textbooks in pathology; this attests the thoroughness and honesty of his laboratory observations.

The collection and dissemination of scientific knowledge was also a predominant interest in his life. He was an organizer of the American Society for Pathologists and Bacteriologists and of the American Society of Cancer Research and served the former in an executive capacity for many years. He edited the American Journal of Pathology for a period of 15 years and the present eminent position of that journal in American Pathology is in large part due to the exercise of his keen discrimination and critical judgment.

His investigations of scarlet and typhoid fevers and of cirrhosis of the liver attracted wide attention and again attests his keen sense of observation and clarity of interpretation. However, his interest was not confined to special fields; it embraced all disease and all pathological phenomena. In his laboratory, autopsies were performed not to substantiate or refute clinical findings but to study disease and, undertaken in this sense each autopsy became a research problem. He abhorred the dilettante in any field of pathology and severely criticized the hasty and indiscriminate methods characteristic of many investigations.

Doctor Mallory's qualities and achievements have been recognized throughout the medical world. He received honorary degrees from Tufts College and from Boston University, and the Mallory Institute of the Boston City Hospital which he directed until 1932 was named for him. In 1935 the highest scientific tribute was paid him, award of the George M. Kober medal of the Association of the American Physicians for outstanding service in Pathology.

Doctor Mallory's greatest achievement, however,

was as a teacher, his greatest contribution the high position attained by so many of his students. American Pathology is today dominated by his disciples and the Mallory tradition of training in honest observation will continue to exert a fundamental influence in medical education.

À Tout Seigneur Tout Honneur

To Doctor John L. Rice, newly elected president of the American Public Health Association, and to Mr. James A. Hamilton, elected president of the American Hospital Association, the Journal extends its sincere and hearty congratulations. Doctor Rice, a graduate of Wesleyan and of Johns Hopkins School of Public Health, and for many years Health Officer of New Haven, has established an enviable record since his appointment in 1934 as Commissioner of Health of New York City. We recall in particular the district health center program inaugurated by Commissioner Rice in 1937 and involving the joint use by the Department of Health and the medical schools of five new health center buildings costing over one and one half million dollars. As a leader in the development of public health programs in this country Doctor Rice is pre-eminent.

In 1938 Mr. James A. Hamilton assumed the position of Superintendent of the New Haven Hospital. A graduate of Dartmouth College and of the Amos Tuck School of Business Administration, Mr. Hamilton brought to his new position the experience gained during three years as assistant professor of Industrial Management at Dartmouth, ten years as superintendent of the Mary Hitchcock Memorial Hospital in Hanover, and two years as superintendent of the Cleveland City Hospital and lecturer at Western Reserve University. The efficiency of the present management of the New Haven Hospital is a tribute to Jim Hamilton. The American Hospital Association has bestowed upon him a deserving honor.

Yet another of medicine's friends and loyal supporters in Connecticut has attained distinction worthy of note. Hugh P. Beirne, Secretary of the State Board of Pharmacy Commissioners, has been elected president of the National Association of Retail Druggists. We can rejoice with Doctor Beirne in this recent honor, all the more because of the vital interest he has shown in deepening the cordial relationship existing between pharmacy and medicine in this State.

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
258 CHURCH STREET NEW HAVEN

HERBERT THOMS NAMED VICE-CHAIRMAN OF THE SESQUICENTENNIAL COMMITTEE

Because of the extended absence from the State of Doctor Blumer, Chairman of the Sesquicentennial Committee, the President of the Society has appointed Doctor Herbert Thoms Vice-Chairman of the Committee to direct the Committee during Doctor Blumer's absence. Doctor Thoms has been the Chairman of the Sesquicentennial Planning Committee for several months.

Sesquicentennial Sub-Committees

Planning Committee: Herbert Thoms, Chairman, New Haven, J. Douglas Gold, President of the Society, James R. Miller, Chairman of the Council, Roy L. Leak, President-Elect, Stanley B. Weld, Editor, Connecticut State Medical Journal, Creighton Barker, Executive Secretary, George Blumer, Peter J. Steincrohn, Daniel Sullivan.

Historical Program Committee: David R. Lyman, Chairman, Wallingford, Samuel C. Harvey, Alfred Labensky, Peter J. Steincrohn, Walter R. Steiner.

Scientific Program Committee: Francis G. Blake, Chairman, New Haven, Edward J. Ottenheimer, Berkley M. Parmelee.

Public Relations Committee: C. Charles Burlingame, Chairman, Hartford, D. Chester Brown, Cecil R. Garcin, Cole B. Gibson, J. Douglas Gold, Crawford Griswold, George M. Smith, Stanley B. Weld.

Historical Exhibits Committee: Arthur H. Jackson, Chairman, Washington, Harold S. Burr, Ernest J. Caulfield, John F. Fulton, Clements C. Fry, George B. Garlick, Charles S. Knapp, Millard Knowlton, Stanley H. Osborn, Maurice T. Root, Benedict N. Whipple.

Local Arrangements Committee: Roy L. Leak, Chairman, Middletown, Carl C. Chase, Harry S. Frank, Charles Russman, Harold S. Speight.

Annual Dinner Committee: Roy L. Leak, Chairman, Michael J. Lawlor, Robert J. Lynch, Michael J. Morrissey, Louis H. Nahum.

Council Meeting

The Council had its monthly meeting on October 15 at the office of the Society. All members of the Council were present except Doctor George Blumer who is absent from the state for an indefinite time.

APPLICANTS FOR ASSOCIATE MEMBERSHIP APPROVED

The Council approved the applications of seven Associate Members who will be recommended to the House of Delegates for election in December. This is the first time that Associate Members have been accepted into the Society under the new by-law that was passed by the House of Delegates this year.

PRINCIPLES AND RECOMMENDATIONS OF THE JOINT CONFERENCE COMMITTEE WITH THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

The Council approved, with minor revisions, The Principles and Recommendations that have been formulated and discussed by Committees from this Society and the Connecticut Pharmaceutical Association. They are published at length elsewhere in this issue.

COMMITTEE TO CO-OPERATE WITH THE STATE FIRST AID CONFERENCE

At the request of the Committee on the State First Aid Conference of which Commissioner Hickey of

the State Police is the Chairman, the Council appointed a Committee from this Society to coöperate with the Conference in its program of first aid education. The Committee is Robert M. Yergason, Hartford, Andrew J. Jackson, Waterbury, Clifford Kuh, New Haven, Lee D. Van Antwerp, Meriden, Harold Wellington, New London.

THE PRESIDENT TO ATTEND CONFERENCE IN CHICAGO

The Council voted to send the President of the Society, Doctor Gold, to the annual Conference of Secretaries and Editors to be held at the American Medical Association headquarters in Chicago on November 14 and 15. The Conference will also be attended by the Editor of the Journal and the Executive Secretary.

THE BUDGET

The Budget Committee reported to the Council recommending a budget for the year 1942. The Council approved this budget and it will be submitted to the House of Delegates at its December meeting.

TREASURER'S BOND

The Council voted that the fidelity bond for the Treasurer be increased to \$35,000.

County Meetings

The President, the Chairman of the Council, and the Executive Secretary have attended the county meetings in Fairfield, Litchfield, New London, Middlesex, and Windham Counties and expect to attend the meetings in the other counties later in the month.

The Middlesex County meeting at the Edgewood Country Club on October 9 was of especial interest. After the business and scientific meeting the wives of members of the Association were invited to dinner which was largely attended. This is an interesting innovation at a county meeting and the Middlesex Association is to be complimented on its initiative.

Meetings in the other counties followed the usual pattern and it seemed that the attendance was rather small and it is to be hoped that interest in these fall meetings may be increased.

MEMBERS ELECTED SEMI-ANNUAL MEETINGS OCTOBER 1941

Fairfield County

Sidney Eglin Beck, Bridgeport
University of Rochester Medical School, 1934

Philip Eglin Benton, Stratford
Columbia University of Medicine, 1934

Thomas Patrick Cody, New Canaan
Long Island College of Medicine, 1936

John Robert Gulash, Bridgeport
Marquette Medical School, 1939

Herbert D. Ingram, Wilton
University of Pittsburgh, 1927

William Kaufman, Bridgeport
University of Michigan Medical School, 1938

John David McMahon, South Norwalk
Creighton University, 1937

Gilbert Emerson Moore, Darien
Yale University School of Medicine, 1934

Nicholas Victor Spinelli, Bridgeport
Marquette University School of Medicine, 1939

Henry H. Weis, Bridgeport
New York Medical College, 1917

Litchfield County

Homer B. Shoup, Jr., Kent
Indiana University, 1935

Middlesex County

V. Gerard Ryan, Portland
Yale University School of Medicine, 1934

Elections from New Haven, Hartford, Windham, Tolland Counties had not been announced at the time this issue went to press.

Special Meeting of the House of Delegates

The date for the usual year-end meeting of the House of Delegates has been changed from December 3, as previously announced, to Wednesday, December 10. The meeting will be held at the New Haven Medical Association, 364 Whitney Avenue. Detailed announcements and agenda will be sent to members of the House.

Positions Open

The Children's Bureau of the Department of Labor has vacancies in its service for physicians who can qualify as specialists in maternal and child health in pediatrics, obstetrics and orthopedics. The salary ranges from \$3,200 a year to \$5,600 a year. Detailed information is available at this office.

SECTION ON GENERAL MEDICINE

Organization Meeting for New Section

The Section on General Medicine, the organization of which has been discussed for some time, will have its first meeting at eight o'clock on the evening of December 18 at the New Haven Medical Association Building, 364 Whitney Avenue.

The Section will organize at this time, discuss by-laws and elect its first officers.

Following the business meeting Doctor Harry E. Bacon of Philadelphia will address the Section on "Office Procedures in Proctology."

Physicians wishing to attend a dinner in honor of Doctor Bacon which will be held at the Medical Association previous to the meeting should notify Doctor Herman S. Cutler, 425 Forbes Avenue, New Haven.

Flies As Carrier of Poliomyelitis

CONNECTICUT PHYSICIANS REPORT INVESTIGATIONS

Doctor John R. Paul and Doctor James D. Trask of the Departments of Medicine and Pediatrics of the Yale School of Medicine reported results of recent investigations in the epidemiology of poliomyelitis before the American Public Health Association on October 16.

The report established that flies can be carriers of the virus of the disease. Prior to their present work Doctor Trask and Doctor Paul and other investigators in Charleston, Detroit, New York and Stockholm found the virus of poliomyelitis in sewage, principally in sewage from hospitals, but also in sewers many miles from any hospitals. This indicated to the investigators that since poliomyelitis is a disease of summer and found in its most severe form in rural areas, the virus in open sewers must come in contact with many living creatures. Moreover it has long been reasoned because of the distribution of the disease it was not unlikely that an insect vector was concerned.

The Connecticut investigators set flytraps in rural areas and otherwise captured insects. They have now reported that on two occasions that captured flies carrying the virus of infantile paralysis, which

when extracted and injected into animals caused quick paralysis and frequently death.

It is not yet clear the exact species of flies that are responsible because there were several varieties in the lots which yielded the virus. There is reason to suspect the green bottle fly or similar species, possibly including the common house fly, which feed upon manure.

The results of the studies reported by Doctor Paul and Doctor Trask add greatly to the knowledge of the spread of poliomyelitis, but complicate the problem of the control of the disease.

Respirators in Connecticut

RESPIRATORS IN CONNECTICUT, THEIR LOCATIONS AND THEIR OWNERS AS REPORTED BY THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS OCTOBER 1941

Bridgeport

Bridgeport Hospital
Englewood Hospital (2)

Danbury

Danbury Hospital

Hartford

Connecticut State Dept. of Health
Hartford Tuberculosis Society
Municipal Hospital (2)

Meriden

Meriden Hospital

Middletown

Middlesex Hospital

New Haven

New Haven Hospital (2)
(1 owned by Conn. State Dept. of Health)
Hospital of St. Raphael

Newington

Newington Home for Crippled Children
(Owned by Conn. State Dept. of Health)

New London

Lawrence and Memorial Assoc. Hospitals

Norwalk

Norwalk General Hospital

Norwich

William B. Backus Hospital

Stamford

Stamford Hospital

Torrington

Charlotte Hungerford Hospital

Waterbury

St. Mary's Hospital
Waterbury Hospital

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THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

Bridgeport Hospital

The Bridgeport Chapter of the American Red Cross is organizing a nurses' aid course under the Chairmanship of Mrs. Clifton C. Taylor. Mrs. Charles B. Goulding has been appointed the instructor to teach the course which is being set up as part of the national defense effort. Mrs. Goulding was clinical instructor at the Bridgeport Hospital from 1939 to 1940. She had previously filled many other positions on the Staff of the hospital, and she holds a B.S. degree in nursing received in 1938 following post graduate courses at Columbia University. She is well qualified to conduct this course, which will begin on October 20, 1941.

The Bridgeport Hospital has retained Mr. William A. Riley of the firm of Stevens, Curtin, Mason & Riley of Boston to make a survey of the hospital to enable it to meet present and future structural needs. Mr. Riley has been retained in a consulting capacity.

Grace Hospital, New Haven

An article written by Mr. Emil J. Monde of Seward and Monde, well known firm of accountants of New Haven, is reprinted here from the *Grace Hospital News*.

CONTRIBUTIONS AND TAXES

In the September issue of the *News*, there was an article written about The Community Chest describing what this organization means to the deserving needy. It also pointed out how vitally interested public hospitals are in the campaign to secure contributions to the Chest since they receive allotments urgently needed to meet the rising trend in their operating costs.

It seems to us that an individual who contributes to a Community Chest or directly to a public hospital is not only doing a service to the community but is doing himself or herself a service in these days of high taxes. Federal income tax rates are rising and each dollar of allowable deductions which can be applied against gross income becomes increasingly important. As the Federal law now stands, an indi-

vidual is allowed to deduct contributions to charitable organizations to the extent of fifteen per cent of his net taxable income computed without the benefit of the contribution deduction.

Thus, for example, a person with a net income of \$10,000 without this deduction would be entitled to an allowance of \$1,500 for such contributions. Let us see what effect this contribution would have on the income tax to be paid by our hypothetical taxpayer. Assuming that he is married but with no dependents, the income is all earned, and using the tax rates in the bill which has just become law, we find that he will pay a tax of \$1,305 if he makes no contributions at all. If he contributes to the full limit allowed him, his tax is reduced to \$976, a reduction of \$329. Thus, he is contributing to the welfare of the community to the extent of \$1,500 but it is actually costing him only \$1,271.

As a further illustration, let us consider the position of the same taxpayer if his net income is \$20,000 without the benefit of the contribution deduction, which would be allowed to the extent of \$3,000 in this particular case. Without the deduction his income tax would be \$4,614 and with the deduction the tax would amount to \$3,444. By making the contribution, he would effect a saving in tax of \$1,170. In other words, the net cost of his \$3,000 contribution was \$1,830. At first glance, this large saving in taxes seems incredible, but when it is realized that the last \$3,000 of this taxpayer's net taxable income is taxed at a total rate of approximately forty per cent, it easily can be seen that these figures are correct.

A very desirable method of making contributions is with property which has appreciated in value in the hands of the contributor. If he sells the property, as for example, securities, he must include the gain in his income for the year. If he contributes the securities, the amount allowed as a taxable deduction will be the fair market value on the date of contribution, and most important, he will not have to report the gain on his income tax return. He has disposed of the property without reporting a taxable

gain but yet has received a deduction to the extent of the full market value of such property.

Thus far, we have considered the matter only from an income tax standpoint, and have previously stated that a taxable deduction under this classification is limited to fifteen per cent of the taxpayer's net income computed without the benefit of this deduction. However, there is no percentage limitation on the contribution itself but merely on the amount deductible for income tax purposes. The individual may contribute any amount he wishes to charitable organizations as defined under the law. The question naturally arises as to what taxable advantage the contributor gains from contributing more than the fifteen per cent allowance. First of all, gifts of this nature are not subject to a gift tax, and second, it reduces the amount of the estate which would be subject to inheritance taxes in the event of the taxpayer's death.

The new Federal tax law increases the inheritance tax rates considerably, and it behooves every taxpayer to take advantage of all the deductions granted by law so as to reduce the heavy burden of taxes which his estate may eventually have to bear. As with the gift tax law, the government does not impose any percentage restrictions on the amount which may be willed to a charitable organization. To illustrate the tax effect of such charitable bequests we may take the case of a decedent who has made no provision of this nature in his will, but whose net estate after all other deductions amounts to \$290,000. The Federal estate tax, under the new rates, would be \$62,340 on this estate. However, if a specific bequest of \$50,000 had been made to a public hospital, for example, the estate tax would have been only \$48,540, a reduction of \$13,800.

It is advisable that a pledge made during the lifetime of the individual be supported by a provision in his will. An outright bequest of this nature under a will raises no question as to its deductibility from the gross estate, whereas a pledge made before death, if unaccompanied by a bequest in the will, may not be allowed as a deduction from the gross estate unless adequate consideration can be proved.

Undoubtedly every reader of this bulletin is interested in the welfare of Grace Hospital and it is suggested that he formulate a program which will enable him to contribute to a worthy cause and at the same time secure all the benefits of the tax reductions the law allows. Such a program might be confined to just one of the methods outlined previously

or it could encompass two or three of them. The important thing is to contribute and save taxes. While this saving becomes more impressive in relation to higher incomes the reduction of the tax burden on lower incomes is sufficiently attractive to warrant the serious consideration on the part of small donors to extend their contributions beyond the limits previously established under prior tax rates.

Hartford Retreat, Hartford

Construction has begun on a new eight story Science Building at the Neuro-Psychiatric Institute of the Hartford Retreat. The new structure will be devoted solely to research in medical and psychiatric science.

The building will fill the needs of the Institute's program of medical and psychiatric research. Here research will be pursued aided by modern scientific equipment. Among the six floors of laboratories in the building will be laboratories for research in electro-encephalography and cardiography, laboratories for dental, eye, ear, nose and throat research, as well as neurological, endocrinological, gynecological and orthopedic laboratories.

The projected building, 100 feet high, will be located on the northwest area of the campus. It will be of brownstone and antique brick construction, adapted English in style and similar to the other new buildings. The new unit will be completely fireproof and will be equipped with sound-proofing, air conditioning and humidity control on certain floors. In addition, it will contain fluorescent lighting throughout.

Two floors of the building will house the Jelliffe Library which was acquired by the Institute last winter, and the Institute's regular medical library. Cataloguing of the collections is now under way.

Construction of the Science Building is the latest step in a program of construction which during the past decade has included the rebuilding and modernizing of all buildings on the campus, as well as the erection of 14 new buildings and the addition of many medical and educational facilities.

Charlotte Hungerford Hospital, Torrington

John Marsh Wadhams, Treasurer of the Charlotte Hungerford Hospital since its incorporation in 1917, died at his home in Goshen on September 17. In the death of Mr. Wadhams not only the hospital but practically all the philanthropic organizations in

Torrington suffered a great loss. He was born in Goshen September 14, 1870. Among the offices held by Mr. Wadhams were:

Chairman of the State Board of Finance from 1913-1928.

Representative to the Legislature from Goshen 1910.

State Senator from the 30th District 1912, 1914 and 1932.

1915 Session of the Legislature—Chairman of the Finance Committee and member of the Banking Commission.

For 30 years Secretary and Treasurer of the Torrington Savings Bank and at the time of his death was President of that Institution.

Vice-President and Trust Officer of the Brooks Bank & Trust Co.

President of the State Savings Bank Association in 1919 and 1920.

President of the National Association of Mutual Savings Banks in 1923.

Organizer and first President of the Litchfield Hills chapter of the American Institute of Banking.

Treasurer of the following organizations: Charlotte Hungerford Hospital, Maria Seymour Brooker Memorial, Torrington Y. M. C. A., Torrington Chapter of the American Red Cross, First Ecclesiastical Society of Goshen, Goshen Public Library, Goshen Academy.

The following resolution passed by the Torrington Chapter of the American Red Cross is an excellent word picture of the life and character of Mr. Wadhams:

"Almighty God has showered His blessings upon countless numbers of His children and has given to them ability, personality, honesty and consideration. In many cases, human weakness has smothered the spark which should have been enkindled into a great brightness of earthly kindness. But it was not so with all. John Marsh Wadhams was an example of what our Heavenly Father looked for and desired in men. Serving as treasurer of this Torrington Chapter since it came into being, he rendered invaluable service, giving of his time as though it were his only obligation. Our Creator found him faithful over a few things, and made him faithful over many. His place in our service and in this community will be difficult to fill, and his principles and example will forever be an outstanding aim and goal for others to follow. Therefore, be it resolved, That the execu-

tive board of the Torrington Red Cross, meeting in special session on this 25th day of September, 1941, humbly bow to the Divine Will of the Supreme Banker of the universe, in calling our late treasurer to his eternal home, after a life so beautifully and usefully spent, that we extend to his family our deepest sympathy."

The Annual drive for membership of the Charlotte Hungerford Hospital Auxiliary was begun on Tuesday, September 20. While all returns are not in, the latest report gives an enrolled membership of 1,455 with more returns to be made.

In this period of rising costs, both in labor and materials, we thought it would be of interest to the hospital administrators of the State to know what is being done in the various institutions to meet these conditions. With that thought in mind we wrote to the administrators asking certain pertinent questions. A resumé of replies received follows:

At the BRIDGEPORT HOSPITAL, Mr. Bartine states that for nine months there has been an increase of 3,000 patient days over the same period of 1940 and that expenses have increased 14.9% but that the increased earnings have been sufficient to meet this increase in expenses. Up to the present time he has increased his salaries 7%.

To meet a large deficit in the months to come, he expects a slightly larger allotment from the Community chest and if that is not sufficient it will be necessary for him to increase rates to patients although rates were raised on December 1, 1940.

At the BRISTOL HOSPITAL, Mrs. Sanborn reports an increased earning of approximately 10% which was sufficient to meet most of the increase in expenses even with the adjustment in salaries in certain brackets. Expenses did increase 15% during the year and the hospital was obliged to use some of its reserve to meet the current needs.

The hospital anticipates a decrease of \$5,000 from the Community Chest but, to meet further rise in expenses for 1942, expects to draw upon reserve cash.

From the DANBURY HOSPITAL, Miss Griffin states that while earnings have increased it has not been sufficient to meet the increased expenses, this increase amounting to nearly \$20,000. She states that salaries have been increased in some departments \$5 and \$10 per month and that in January all wards and rooms were raised 50 cents per day.

She is very fortunate indeed in reporting an increase from \$5,000 to \$8,000 from the Community Chest this year in her allotment but that with higher costs of administration, it may be necessary for them to increase ward and room rates.

At GRACE HOSPITAL, New Haven, earnings for the nine months period this year increased about \$14,000 and expenses increased \$22,000. The Directors are planning a general wage increase, especially in the lower paid groups, which will add about \$36,000 a year to the payroll and are anticipating a \$15,000 to \$18,000 increase in the cost of hospital supplies for the ensuing year.

It is not expected that there will be any increase in the Community Chest allotment and, in order to meet these increases, consideration is being given to sufficient increases in rates to meet the anticipated operating expenses for 1942.

At the GREENWICH HOSPITAL, Mr. Loase reports as follows: Anticipating increases in operating expenses we have, as of July 1, 1941, raised all our board rates by 50 cents per day. A recently installed cost system revealed that our charges for the use of the delivery room and nursery were far below the cost of these services. We, therefore, have at the same time adjusted these rates to bring them closer to the actual cost of operating these divisions.

Apparently due to improved business conditions and the ever growing popularity of the Hospital Service plans, our revenue from private and semi-private patients has increased by 23.8% and 16.1% respectively, while the income from our ward patients declined by 2.5%. Our net increase in earnings for the nine months of this year compared with the same months of last year was 11.2%.

We have not as yet felt the full force of the increase in price in the various commodities and our expenses for the 3 quarters of 1941 rose by only 3%.

Offers of higher wages and shorter hours by nearby manufacturing plants have made it increasingly difficult for us to secure suitable help for our House-keeping and Dietary Departments. On October 1, we found it advisable to increase wages in these departments, hoping thereby to keep our employees and to attract a better type of worker.

As our occupancy percentage is pretty close to the full capacity we do not expect any substantial increase in patients days for the coming year. But we do hope that the increases in rates will offset the inevitably higher operating costs in 1942, and consequently do not anticipate an increase in the oper-

ating deficit. As a matter of fact, our 1942 Budget calls for a slight decrease in the deficit.

At the MILFORD HOSPITAL, Miss Oddy reports an increase of nearly 25% in the number of patients admitted during the past year with a still greater increase in income because of the greater number of patients able to pay their bills on discharge and the increased use of private rooms.

Rates were increased in October 1940 and salaries in September this year.

From the NEW BRITAIN HOSPITAL, Mr. North reports increased earnings which have kept pace with increased expenses. He states that he has been obliged to increase wages and is still making adjustments in an effort to meet present conditions. He does not feel that he can expect any greater volume of business in 1942 as he has been operating at full capacity in 1941. An anticipated deficit next year will make changes upward in the rate structure to patients.

At the LAWRENCE AND MEMORIAL ASSOCIATED HOSPITALS, INC., New London, Mr. Hancock reports as follows:

Due both to the general labor situation and to the increases in costs of supplies, we have recently put into effect quite comprehensive raises in our rates. Every bed for adults in the hospital was increased 50 cents per day. On the ward service this meant a new rate of \$3.50 per day; on semi-private service, \$4.50 per day (one three-bed room, \$5.00). In the private rooms, the range is now \$5.00 to \$7.50 per day (one room at \$8.50). In the Children's Building, the old ward rates of \$1.50 and \$2.00 per day have been increased to \$2.50 and \$3.00 per day; semi-private, from the old rates of \$2.00 and \$3.00 per day to all at \$4.00 per day; private, \$4.00 to \$5.00. Also, we are doing something we never did before, that is, charge for new-born babies, the rates being \$1.00 per day for private or semi-private and 50 cents per day for ward.

As our increases have been in effect for only two months and since the prices for supplies are so unstable, it is difficult to say whether the increased income will balance the increased expenses. We estimated that our higher charges will bring in approximately \$28,000 more per year. We have already made increases in salaries amounting to about \$7,000 yearly and will probably have to do even more along that line. We believe, however, that the increased income will result in holding down the deficit to normal proportions.

Here in New London, we are very directly affected by the defense program. The strongest effect we have had has been on the maternity service. During our last fiscal year our births averaged 70 per month. In the month of July, however, it sky rocketed to 112. We made application to the P.W.A. for a building grant to put up a new maternity wing but have not heard from it. Meanwhile we are making plans to accommodate a monthly average of 100 or more births. We definitely expect that not only the Maternity Building, but the rest of the hospital will be running very close to capacity as long as the defense activities are at such a height in this area. Only this morning we talked with a representative of the Defense Housing Project in Groton where they have 200 families of employees of the Electric Boat Company going in this week. He told us that at least 75 of the women are prospective maternity cases within the next few months.

Our compensation work also has increased, of course, because there has been not only the tremendous jump in the number of employees at the Electric Boat Company, but there is also the new Thames River Bridge under construction and considerable other building going on.

At the NORWALK HOSPITAL, Mr. Brough shows increased expenses of about 9% and revenue slightly over 8% with a final loss for the year of over \$20,000. He says that to meet this increase in expenses, charges to patients were increased on May 1 approximately 5% and it is probable his hospital will have to further raise these charges as he does not expect any larger allotment from the Community Chest. He, too, is not able to look forward to any larger volume of business in 1942 as he was crowded during 1941.

We think the last paragraph of Mr. Brough's reply is well worth including.

"The problem of salary adjustments and personnel continues uppermost. Unable to match inducements offered by defense industry, we are handicapped in retaining competent and well trained employees. From time to time salary adjustments are made in individual cases as seems necessary and wise. Notwithstanding, the labor turnover is rapid, discon-

certing and embarrassing. With chin up, we struggle along, keeping in mind that we have much to be thankful for."

From the JOHNSON MEMORIAL HOSPITAL, Stafford Springs, Miss Henrietta Bigney reports as follows:

"Our earnings in the last 8 to 9 months have increased noticeably, partly due to the fact that in January 1941 we increased our rates in rooms, wards, and nursery, and also there has been a greater demand for private rooms, especially with maternity cases.

"All expenses have increased, foodstuffs having gone up steadily and many other supplies seem unnecessarily high. We increased the wages of our maids to keep in line with the factory workers. We are hoping not to have too great a deficit but will have to meet it as best we can from our endowment.

"You asked about our allotment from the Community Chest. We are very fortunate in that there has never been a penny raised from any sort of public drive in the history of this hospital. We are endowed and intend to keep within our endowment as long as possible. All town cases are charged as any other ward case and the Town reimburses us at ward rates. We hope to be able to continue this policy."

At the STAMFORD HOSPITAL, Doctor Young reports much along the same lines. Earnings increased slightly but not in proportion to the expenses. He is now planning some increase to maids, orderlies, and others and while he anticipates a larger deficit, he hopes to meet it by raising the rates to patients. He, too, has no Community Chest and must meet the rising costs only through charges to his patients. He is planning a 50 cent per day increase for private and semi private and \$1.00 per day for ward patients for which he has only been charging \$3.00 per day.

At the CHARLOTTE HUNGERFORD HOSPITAL, Torrington, Doctor Buck reports an increased earning but not sufficient to meet increased expenses, which increase amounts to about \$3,500, including about \$2,000 salary raises.

He has no Community Chest and feels that if costs continue to rise it will be necessary to raise rates.

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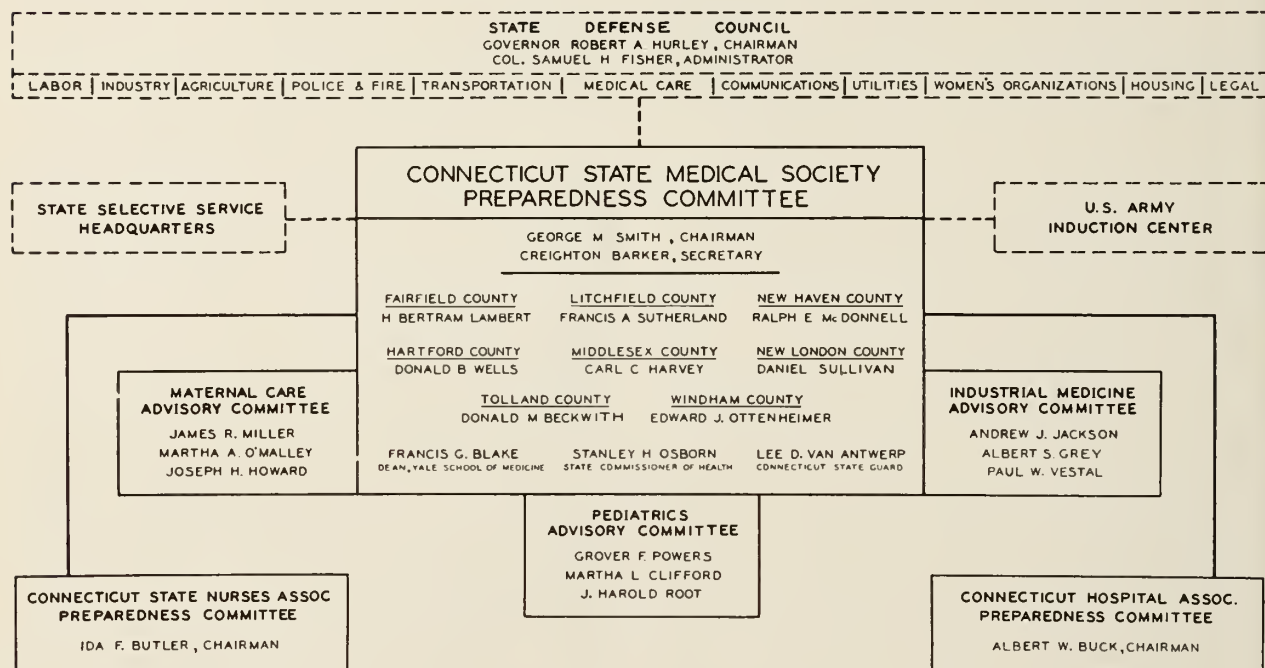
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MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

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DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic
FRANCIS G. BLAKE, M.D. Dean, Yale School of Medicine	STANLEY H. OSBORN, M.D. State Commissioner of Health	LEE D. VAN ANTWERP, M.D. Connecticut State Guard	

CONNECTICUT STATE MEDICAL SOCIETY PREPAREDNESS ORGANIZATION



PROGRESS REPORT COMMITTEE ON MEDICAL PREPAREDNESS THE CONNECTICUT STATE MEDICAL SOCIETY

The earliest objective of the Committee on Medical Preparedness was to aid the State Selective Service Headquarters in providing for medical examinations under the Selective Service. Up to now about 350 members of the Society have voluntarily served in the Selective Service and the Society and the people of Connecticut are deeply grateful to them. As time has gone on experience has shown ways in which the medical examination function in the Selective Service could be simplified and these measures have been put into effect. Over twelve thousand enrollees have been examined and Connecticut's quota in the draft has at all times been

met. Between 27 and 28 per cent of enrollees examined have been found physically disqualified by the local examining boards and between 8 and 9 per cent of those accepted have been rejected by the Army Induction Center. This record compares in the most favorable fashion with experience in other states.

After enrollees have been passed by their local Selective Service boards they must be "processed" by the Army Induction Center at which point they are actually inducted into the Army. There is one Induction Center in Connecticut which is located at Hartford. The operation and manning of the Army

Induction Center in Connecticut varies somewhat from the pattern followed in other states. In most states the medical personnel at the Induction Center is composed of Army officials. In Connecticut, however, the local civilian physicians were called upon to supply this service. This type of organization for the Induction Center placed an additional and important responsibility on your Committee on Medical Preparedness and throughout the year in which the draft has been operating the Center has been manned by Connecticut physicians. From the start this activity has been ably supervised by Doctor Donald B. Wells.

Last year your Committee on Medical Preparedness coöperated in the closest manner with the State Defense Council that had been appointed by Governor Baldwin of which Colonel Sanford H. Wadhams, a member of this Society, was the Chairman. Toward the end of the 1941 Assembly legislation was passed which made provision for a State Defense Council under appointment by the Governor. This Council was appointed by Governor Hurley in the late spring and the Chairman of the Committee on Medical Preparedness of the State Medical Society is the medical member of that Council. After the Council was organized, the required purposes of your Committee on Medical Preparedness became more clearly outlined.

As the problems that confronted the Committee unfolded it became necessary to have advice and consultation in fields that were not represented on the Society's Committee as originally appointed. To that end three additional members have been added to the Committee, they are Francis G. Blake, the Dean of the Yale School of Medicine, Stanley H. Osborn, State Commissioner of Health, and Major Lee D. Van Antwerp of the Connecticut State Guard has been assigned to the Committee under orders from the Adjutant General of the State. There are advisory committees in: Industrial Medicine consisting of Doctor Albert S. Gray of the State Department of Health, Doctor Andrew J. Jackson, and Doctor Paul W. Vestal; in Pediatrics: Doctor Grover F. Powers, Doctor Martha L. Clifford of the State Department of Health, and Doctor J. Harold Root; in Maternal Care: Doctor James R. Miller, Doctor Martha A. O'Malley of the State Department of Health and Doctor Joseph H. Howard. The Committee on Preparedness from the Connecticut Hospital Association has worked in coöperation with your Committee and important plans have been jointly developed. The Society is

also represented on the State Committee on Nutritional Problems by Doctor John C. Rowley and there is a special committee from the Section on Neuropsychiatry that is engaged in a study of psychiatric problems.

Intimate association has developed with the Connecticut chapters of the American Red Cross and the recently issued memorandum concerning the relationship of the Red Cross to the civilian defense effort has gone far to clarify the position of the Red Cross in the defense program in this State.

Some months ago Mayor F. H. LaGuardia was designated by the President to be the Administrator in the Office of Civilian Defense for the nation. Mayor LaGuardia appointed as his chief medical officer Doctor George Baehr of New York City. Soon after Doctor Baehr's appointment the Chairman of your Committee and the Secretary of the Society visited him and spent the greater part of a day with him discussing the medical activities in national defense. The pattern of organization in the Office of Civilian Defense calls for an administrator in each of the nine Army Corps Areas. Connecticut, with the other New England states, is a part of the First Corps Area. Mr. James Landis, formerly Chairman of the Securities and Exchange Commission, now Dean of the Harvard Law School, has been appointed Civilian Defense Administrator for the First Corps Area. Mr. Landis has visited Connecticut and conferred with Colonel Fisher, the Administrator of the State Defense Council and other members of the Council. Connecticut's plans are being developed in coördination with the Area scheme. There will be a Corps Area Medical Officer attached to the Office of the Area Administrator. As yet this medical officer has not been appointed and until he has been developments here have been held somewhat in abeyance in order that they might be further pursued in consultation with the Area Medical Officer. The principle of the emergency medical service, modified from the English form, has been recommended by the Chief Medical Officer of the Office of Civilian Defense and while it is likely that some scheme of organization including emergency field service units will be adopted further consideration is necessary.

Officer from State Guard Assigned to Preparedness Committee

Doctor Lee D. Van Antwerp of the Undercliff Sanatorium, Meriden, a Major in the Medical Corps of the Connecticut State Guard, has been assigned

as a liaison officer to the Society's Preparedness Committee under special orders No. 64 of the Adjutant General of the State of Connecticut. The purpose of Major Van Antwerp's assignment to the Committee is to coordinate the civilian defense plans of the Committee with the military plans of the State Guard.

Changes in the Selective Service

SPECIAL BOARD ESTABLISHED IN NEW HAVEN FOR UNIVERSITY STUDENTS

The State Selective Service has authorized a special board at New Haven to examine enrollees whose examinations have been transferred from other boards outside of the State, especially students in Yale University who registered at their homes and whose examinations are to be made in Connecticut.

This Board consists of Orville F. Rogers, examiner, Matthew Griswold, and Joseph Mignone, alternates.

New Haven Advisory Board

Louis H. Nahum to be Chairman in place of George Blumer, resigned

Board 2B

John F. McGrath, Hartford, resigned
Wilmot C. Townsend, Hartford, resigned
John J. Sayers, Hartford, appointed as alternate examiner
James R. Cullen, Hartford, appointed as alternate examiner

Board 9B

Thomas J. Sullivan appointed examiner

Board 11A

Thomas H. Russell, New Haven, resigned
Courtney C. Bishop, New Haven, appointed as alternate examiner
William F. Peltz, New Haven, appointed as alternate examiner

Board 16B

Max H. Ruby, Waterbury, resigned

Board 23A

Maurice N. Levy, Bridgeport, resigned

Members of the Society Ordered to Active Duty (As of October 14)

Harry Apter, Hartford
Edward B. Hopper, Stamford
Royal A. Meyers, Watertown

Orders Revoked

Thaddeus J. Valenski, Thompsonville

Changes in Operation of Draft Law

As the Journal has previously pointed out trials of various methods for the operation of the Selective Service have been carried on in several states. As the results of these experiences it is probable that the procedure for medical examinations in the Selective Service may be changed.

Doctor Leonard W. Rowntree, Chief Medical Officer of the Selective Service, believes that the method for selecting physically qualified recruits may be improved. At present there are approximately 27,000 doctors and 6,000 dentists serving with local draft boards throughout the country and as a result of examinations about 43% of enrollees are rejected (Connecticut's rejection rate is between 27 and 28%).

The man who passes his local board examination has every reason to suppose that he is due for a term in the Army and he gives up his job, may sell his farm or his car. But before he actually becomes a soldier he must be "processed" at the Army Induction Center where he may be rejected for some defect that the local physicians did not discover (the Induction Center rejection rate in Connecticut is 8.5%).

Efforts have been made to correct this unfortunate occurrence and three methods of examination have been tried. In some Pennsylvania districts the present system of rigid local examination was continued but a man was assured that after reporting at the Induction Center he would have a month's leave before starting active service. This made quite sure that he was going to be accepted in the Army and gave him time to wind up his personal affairs before leaving home.

In Ohio an experiment has been tried of relieving the local boards entirely of physical examinations. All eligible men were sent directly to the Induction Center to be passed on directly by the physicians attached to the Induction Board. This is reported to have resulted in an extreme bottle-neck.

A compromise between these two methods is still under way in Indiana. Local physicians look over the enrollees for gross defects such as missing arms and legs, obvious tuberculosis, recent record of insanity, and so forth, but they do not go into details. If an enrollee is superficially all right as a result of this examination he is sent to the Induction Board.

This method seems to have a good deal to recommend it and in any event the man has no reason to close up his civilian affairs until he has finally been approved.

During this first year of the Selective Service Connecticut has continued to operate under the original system of sending the enrollee to the Induction Center for examination immediately before going to the Reception Center. This has not been a perfect arrangement. It involves a good deal of lost motion and has resulted in some inconvenience and embarrassment for enrollees who have been rejected at the Induction Center. Experience has shown, however, that by the time a recruit gets through the examinations by the local board and the Induction Board in Connecticut and is sent to the Reception Center he is a physically qualified and desirable recruit. The number of men who have been returned to their homes from the Reception Center from Connecticut is negligible.

Selective Service announced the trial of a new method in the State under which enrollees will be sent to the Induction Center soon after they have been examined by their local board even though the time for their call into the Army may be some weeks off. After examination at the Induction Center they will be told whether or not they are acceptable to the Army and will be allowed to go home and arrange their personal affairs and wait their call. When the call does come they go directly from their homes to the Reception Center. If too long a time is not allowed to elapse between the Induction Board examination and departure for the Army this system should go far to eliminate some of the personal inconveniences of the past.

Red Cross to Coördinate Efforts With Office of Civilian Defense

According to a joint statement issued by the U. S. Director of the Office of Civilian Defense, F. H. LaGuardia, and the Chairman of the American National Red Cross, Norman H. Davis, State and

local defense councils are the official agencies responsible for the coördination of all available resources which may be required for civilian protection in the event of belligerent action. Defense Councils should therefore acquaint themselves with the resources of the local Red Cross Chapters in providing food, clothing, shelter, nursing care, transportation, and other basic necessities and should integrate them into the comprehensive local program. Duplication of trained and experienced personnel and of available supplies of the Red Cross should be avoided except where supplementation is essential to meet the anticipated needs of the community.

92 American Doctors Have Qualified for Service in Great Britain

A total of 230 applications, up to September 4, had been received by the American Red Cross from physicians wishing to enroll with the Royal Army Medical Corps in response to a British Red Cross request for American physicians.

Of these 138 had been found unqualified because of age, lack of citizenship or other similar reasons. Ninety-two have been qualified and 42 have been given passports to Great Britain; the remaining 50 are in process.

The Cost of Health in Connecticut Towns

The State Department of Health has released some interesting figures in its *Health Bulletin* for August 1941, showing the average expenditure per capita for public health in each Connecticut city and town in 1940. Greenwich tops the list with an average expenditure of \$2.43 while the lowest figure from any town is \$0.02 from Killingly. Old Lyme spent \$2.05 per capita, and Hartford leads the large cities with \$1.28. Granby is but one cent better than Killingly and among the six largest cities Waterbury is low with \$0.56 per capita. The average for the state is \$0.76.

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PUBLIC AFFAIRS

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HARRY W. MARSH, *Personnel Director, State of Connecticut*

The State of Connecticut gives full time employment to over one hundred physicians. This group includes highly trained specialists in the fields of public health, psychiatry, tuberculosis, obstetrics, pediatrics and in general medicine. Except for a small number of appointive officers, recruiting and selection for all of these positions is the responsibility of the State Personnel Department under the Merit System Law.

The chief purpose of a merit system law for the employing of personnel in the public service is to protect the service from political upheaval because of changes in administration through the election of public officials. Other purposes of the merit system are to provide a device which will discover the best man for any job in government service, give that man the opportunity for a career in the service and eliminate incompetent persons. These goals are achieved with varying success depending upon the circumstances surrounding the provisions of the laws themselves and the administrative difficulties encountered.

The most significant and important elements involved in the functions of the Personnel Department with respect to medical service are methods for the recruitment of personnel and the establishment of adequate rates of pay. Once a satisfactory group of recruits for a position has been obtained through the established mechanism of advertising the positions, the applicants are graded in an open competitive examination. For medical positions these examinations have taken the form of searching personal interviews carried out by a committee of physicians appointed by the Personnel Department from among the members of the Connecticut State Medical Society chosen for their knowledge and experience in special fields. The judgment of these examiners with respect to the qualifications for the

medical positions in State institutions and their judgment with respect to the actual possession of these qualifications on the part of candidates is the controlling factor for the selection of medical personnel.

There has been doubt and discussion as to the wisdom of attempting to apply the Merit System to State institutions in Connecticut, particularly to the medical service. Some of the objections that have been put forward are: (a) well qualified physicians hesitate or refuse to submit themselves in competition with others in the examination processes which are set up under a merit system; (b) recruitment by an independent agency such as the Personnel Department fails to discover the best qualified persons available; (c) the provisions of the law tend to restrict selection to persons who have been residents of the State of Connecticut for a period of at least two years; (d) the protection provided for employees in the classified service against removal for political reasons, or other unjust causes, results in difficulties for the head of an operating agency in ridding the service of incompetent members of his staff; and (e) salary schedules and maintenance allowances are not sufficient to attract the best medical personnel.

It is neither intended nor possible to discuss these objections at length. Some of them are well founded and clearly realized while other criticisms attributed to the Merit System are criticisms which lie in any case against conditions under which employment would have to be made, Merit System or no Merit System. For example, the amount of money made available for a position is part of the fiscal function of the government and not necessarily due to the operation of any Merit System, and no Personnel Department can create qualified persons and make them available for positions in the public service.

New plans are being developed in the Department to discover the existence of good men in any part of the country who might be attracted to employment in Connecticut institutions. Also ways are being contemplated whereby these men may be selected by a rating of their qualifications and experience without putting them to the inconvenience and expense of a visit to the State for examination. However, no examination process, no matter how perfect it may be, can rise above the quality of the material submitted for examination.

State service in Connecticut offers many fine and adequately paid opportunities for employment for physicians and the purposes of the Personnel Department will be furthered by a sympathetic understanding of its objectives by the physicians in the State from whom assistance and suggestions will be welcome.

Members of The Connecticut State Medical Society who have served on examining committees for the Personnel Department are: Creighton Barker, Stanhope Bayne-Jones, George Blumer, Alfred L. Burgdorf, Hugh B. Campbell, Max Climan, David J. Cohen, Howard S. Colwell, Mildred Couch, Edward H. Crosby, James M. Cunningham, Joseph N. D'Esopo, Muriel C. Downer, John H. Foster, Clements C. Fry, Louis P. Hastings, Chales Hoffman, Benjamin G. Horning, Frank S. Jones, Eugen Kahn, Ralph E. Kendall and Robert P. Knapp, Millard Knowlton, Arthur B. Landry, Joseph I. Linde, Clifford D. Moore, William H. Morriss, Henry B. Moyle, Thomas P. Murdock, Edward J. Ottenheimer, Ashley W. Oughterson, Paul S. Phelps, George K. Pratt, Edwin Pyle, Everett S. Rademacher, Frederick W. Roberts, Peter J. Steincrohn, Charles W. Stephenson, Francis A. Sutherland, Paul P. Swett, Lloyd J. Thompson, William B. Terhune, Paul W. Vestal, Carl P. Wagner, Walter Weissenborn.

News from Washington

COMPENSATION FOR MEMBERS OF LOCAL BOARDS UNDER SELECTIVE TRAINING AND SERVICE ACT

H. R. 5535, introduced by Representative Knutson, Minnesota, August 8, and pending in the House Committee on Military Affairs. A bill providing for compensation at the rate of \$5 a day for members of local boards under the Selective Training and Service Act of 1940, as amended.

This bill proposes to amend the Selective Training and Service Act of 1940 so as to provide that each

member of each local board shall receive as compensation for his services \$5 for each day on which he performs board duties, and in addition, shall receive travel expenses at the rate of five cents a mile and subsistence expenses, or a per diem in lieu thereof, while away from his official station on duties of the board.

DEFERMENT OF COLLEGE AND UNIVERSITY STUDENTS UNDER THE SELECTIVE TRAINING AND SERVICE ACT

H. R. 5635, introduced by Representative Martin J. Kennedy, New York, September 11, and pending in the House Committee on Military Affairs. A bill to amend the Selective Training and Service Act of 1940 so as to provide for the deferment, in time of peace, of certain college and university students.

In time of peace, this bill provides, any person who has entered upon attendance for any academic year (1) at any college or university which grants a degree in arts or science, to pursue a course of instruction satisfactory completion of which is prescribed by such college or university as a prerequisite to either of such degrees; or (2) at any such university to pursue a course of instruction to the pursuit of which a degree in arts or science is prescribed by the university as a prerequisite, and who, while pursuing such course of instruction, is selected for training and service under the Selective Training and Service Act prior to the end of such academic year, shall, on his request, be deferred from induction into the land or naval forces until the end of such academic year.

NEW BUILDING FOR ARMY MEDICAL LIBRARY

On September 24, the President approved a bill, H. R. 5146, authorizing an appropriation of \$4,750,000 to construct a new building for the Army Medical Library and Museum and to purchase a site on which to construct the building (Public Law No. 256, 77th Congress). As pointed out in FLB-7, the Seventy-fifth Congress, in 1938, authorized an appropriation of \$3,750,000 for the new building but failed to make any provision for the purchase of a site, it being then contemplated that the new structure would be built on property already owned by the Federal Government. A suitable government owned site, however, could not be found and it was necessary for Congress specifically to authorize the acquisition of a new site which it did in the law recently signed by the President.

While this bill has already been signed by the

President and is now law, the money authorized by it must yet be actually appropriated by the Congress before a site can be acquired and the building constructed. Ordinarily when Congress authorizes an appropriation of money for stated purposes, the actual appropriation of that money follows as a matter of routine. From a discussion that took place on the floor of the House of Representatives when H. R. 5146 was given final consideration, however, some doubt is created as to whether the sum authorized will be immediately appropriated so that the project can be speedily carried to conclusion.

CITIZENSHIP AS A CONDITION OF MEDICAL LICENSURE

H. R. 5631, introduced by Representative Randolph, West Virginia, September 8, and pending in the House Committee on the District of Columbia. A bill to amend an act entitled "An Act to regulate the practice of the healing art to protect the public health in the District of Columbia," approved February 27, 1929.

The purpose of this bill is to impose a citizenship requirement on applicants for licenses to practice the healing art in the District of Columbia. A bill to make citizenship a prerequisite to medical licensure in Connecticut was defeated by the 1941 General Assembly.

Famous British Psychiatrist Coming to U. S.

One of England's foremost specialists in psychiatry and neurology has been granted a leave of absence from the R. A. F. by the British government to report to the American medical profession his first-hand observations on the psychological effects of "blitz" warfare on armed forces and civilian population.

Doctor R. D. Gillespie, who is now chief psychiatrist for the British Royal Air Force, is coming to this country at the request of the Salmon Committee on Psychiatry and Mental Hygiene of the New York Academy of Medicine. He will deliver the Salmon Memorial Lecture in the New York Academy building November 17, 18 and 19, speaking on "Psychoneuroses from the Standpoint of War Experience."

The New York lectures will be followed by addresses before the Chicago Neurological Society, the Chicago Institute of Medicine and the Illinois Psychiatric Society in Chicago. Dates for these lec-

tures as well as lectures in Toronto, Ontario and San Francisco, California, will be announced later.

Doctor Gillespie's observations made under actual war conditions are expected to be of inestimable value to American psychiatrists in formulating plans for maintaining civilian morale in wartime. His lectures will also give his hearers new information concerning the pressing psychiatric problem of today—the psychoneuroses.

Doctor C. Charles Burlingame, chairman of the Salmon Committee which each year chooses an outstanding specialist in psychiatry, neurology or mental hygiene for the Salmon Memorial Lecture, has issued a general invitation on behalf of the Committee to members of the medical profession and their friends to attend. Doctor Gillespie will be the 9th lecturer who has been selected from the top-ranking psychiatrists and neurologists throughout the world who have made the greatest contribution to their field during the preceding year. Selection for delivering the Salmon Lecture has been likened to selection for the Pulitzer Prize in letters.

Among Doctor Gillespie's many important findings concerning the psychological effects of modern warfare on civilians and combatants is the fact that chronically neurotic people and those suffering from mild depressions have become chronically heroic and self-sacrificing under the stress of bombing raids. Also, he has noted that women stand up as well if not possibly better than men under civilian bombings.

Pay Your Doctor Week

The fourth annual "Pay-Your-Doctor Week" will be observed this year November 2 to 8. It was inaugurated in 1938 by California Bank in Los Angeles for the purpose of paying tribute to the members of the healing profession who quietly but relentlessly continue the battle against disease and sickness, particularly at this time when much of the world is engaged in destroying rather than preserving life. Funds are available in banks sponsoring this week for the purpose of paying doctor bills.

College of Pharmacy Added to University

The University of Connecticut announces with pleasure that in accordance with a recent act of the Connecticut General Assembly the Connecticut College of Pharmacy in New Haven has been added to the schools and colleges of the University.

INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

CLIFFORD KUH, M.D., Chairman, New Haven

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NORMAN E. GISSLER, M.D. Middletown	ROBERT P. KNAPP, M.D. South Manchester	ELLIOTT H. METCALF, M.D. Rockville	CHARLES F. YEAGER, M.D. Bridgeport
ALBERT S. GRAY, M.D. Hartford	ARTHUR B. LANDRY, M.D. Hartford	RICHARD O'B. SHEA, M.D. Bridgeport	

Alice Hamilton On Current Problems

Demonstrating the truism that long and extensive work in the field enables one to inject into a talk innumerable, personal experiences and historical incidents which add interest and vividness, Doctor Alice Hamilton, Emeritus Professor of Industrial Medicine, Harvard University School of Public Health, provided a most enjoyable and instructive evening for members of the New Haven Industrial Safety Conference at a meeting at the New Haven Y. W. C. A. on September 16. The talk was arranged by the Society's Committee on Industrial Health.

Doctor Hamilton first traced in broad terms the tremendous advances in industrial hygiene which have occurred in the past twenty-five years. During the last war, she said, one of her assignments was to control poisoning from nitrous fumes in munition plants. Instead of waiting for instructions where to go, for scarcely anyone knew where the plants were, she looked over the landscape at night and, wandering like a lost child of Israel in search of a homeland, wherever she saw orange colored fumes arising from a smoke stack, thither she went.

One of the chief industrial hazards, then and now, arises from the effect of combustion, both complete and incomplete, upon gases which occur naturally in the air. Incomplete combustion produces carbon monoxide, which is the gas ubiquitous and as old as time. Complete combustion occurs under more favorable oxygen supply with the production, as in welding, of oxides of nitrogen.

The use of welding, both electric and oxyacetylene, has received tremendous stimulus since the inception of the national defense program. In the fabrication of metal it has largely replaced the riveting of old. The gases produced in the heat of the process, in addition to oxides of atmospheric nitro-

gen, may be oxides of any of the metals which enter into the welding process—the base metal being welded or the metal of the welding rod or its coating or any combination of these. Thus iron oxide or zinc oxide may be formed. But the use of new or “secret” metals, fluxes and rod coatings may give rise to uncommon poisons. For example, in addition to the well-recognized, insidious pneumonia from nitrous fumes or the ague seen in brass (zinc) founders, we may meet cadmium poisoning, which is a serious menace, or rare cases of poisoning from manganese dioxide, which produces an incurable paralysis.

Welding is being done today in many new fields and in new shops and plants, where heretofore the process was essentially unknown. The frame of the modern truck, pleasure car, army tank, submarine, battleship, streamlined train, and even the small electric motor, would be much heavier and take longer to build were it not for modern welding. Doctor Hamilton told of special preventive problems she had encountered, as where the worker was confined in the small compartment of an airplane fuselage and adequate ventilation was well-nigh impossible.

She summed up protective measures, as follows:

1. Use of less poisonous substitutes.
2. Use of fume- and dust-tight apparatus.
3. Catching the gas and getting rid of it (exhaust system).
4. Blowing in fresh air.
5. Individual protection through respirators, helmets and other equipment to be used on one's person.
6. Shortening exposure.

To emphasize the last point she characteristically referred, in closing, to an historical incident. As early as 1600 Austria enacted legislation shortening

the working day in mercury mines to four hours. A man working thirty hours a month received a full month's pay.

Tailor-Made Service

In a talk before the annual meeting of the American Public Health Association at Atlantic City on October 15, Doctor Crit Pharris of the Bureau of Industrial Hygiene of the Connecticut State Department of Health emphasized the need of fitting industrial medical service to the specific requirements of the plant. He pointed out that the type and extent of health care needed in a given plant should be based upon the various health problems involved and such determinations should be made in the same way as that used in the development of a complicated manufacturing process, or the construction of a specified type of plant building. To say that a certain plant employing 450 people should have a part time general surgeon or physician and a full time nurse is not adequate or scientific, unless it has been determined through analysis of the various problems in the plant that these services will be adequate. A careful study might reveal that the services of a physician, having special training in industrial medicine, would be necessary and that two trained industrial nurses should be employed instead of one ordinary nurse.

Industry represents one of the greatest markets for medical service to be found today and the potential purchasers far outnumber those who now provide modern medical progress. They are interested in procuring any equipment and services which will be advantageous and they will be much more interested in the "blue prints" and "specifications" of medical programs designed to meet their needs than in the "pig in the poke" variety.

Doctor Pharris contended that logical and sensible efforts are being made in more than one camp to bring about the type of industrial health protection which will be adequate to meet the needs in individual plants and which will be respected and utilized by the beneficiaries. These services will be offered to industries on a "tailor made" basis so as to better insure that the type and extent of care needed, as revealed by specific plant surveys, will be provided. The small plants will be on the priority list and every effort will be exerted to guarantee their workers medical care equal in quality to that to be found in the larger plants. This program is not just concerned with the present industrial situation, but is also being

developed with the objective of insuring to all industrial workers for all time that every effort will be made to protect them against their jobs and their jobs against them.

Meeting With Manufacturers

An informal meeting to consider the future program for developing industrial medical services in Connecticut took place at the offices of the Manufacturers Association of Connecticut in Hartford on September 24. Colonel Fred U. Conard and Mr. W. Adam Johnson represented the Manufacturers Association and Doctors Albert S. Gray and Clifford Kuh, the Medical Society.

A preliminary survey of industrial medical service in Connecticut, based on an analysis of the inquiry forms returned by manufacturers receiving the brochure, "Conservation of Man Power," was discussed. The analysis will be completed and referred to the industrial health committees of both organizations. Subsequently, a joint meeting of the executive subcommittees will be called to decide on a definite follow up program.

California Follows Connecticut

At the July meeting of the California State Board of Health, a resolution was adopted prohibiting the use of mercurial carroting compounds in California hatters' fur cutting and fur felt hat manufacturing plants after December 1, 1941. This action is a direct result of the conference held on May 19, 1941, by the Surgeon General of the United States Public Health Service, previously reported in these columns, at which proposed state regulations governing the use of hatters' mercurial carroting solutions were unanimously approved in principle by representatives of the Hat Institute, Inc., the Hatters' Fur Cutters Association, and the Connecticut State Department of Health. Other States which have adopted similar regulations are Delaware, Rhode Island, Kentucky, Vermont and Michigan.

Enlisting the Clinical Specialties

The Council on Industrial Health of the American Medical Association has announced that committees have been formed to consider specific health problems in the following sections of the American Medical Association: Dermatology and Syphilology, Ophthalmology, Orthopedic Surgery, Preventive and Industrial Medicine and Public Health, and Radiology.

Under this arrangement there should be no difficulty about competent handling of all kinds of queries in industrial health and in general and special medicine relating to occupational problems.

Library Additions

The Committee on Industrial Health has recently received the following new publications: PROTECTING PLANT MANPOWER, Practical Points on Industrial Sanitation and Hygiene, United States Department of Labor, Special Bulletin No. 3; CONTROL OF WELDING HAZARDS IN DEFENSE INDUSTRIES, United States Department of Labor, Special Bulletin No. 5; CONSERVING MEN, MONEY, MATERIALS IN ESSENTIAL INDUSTRIES, Welfare Division, Metropolitan Life Insurance Company, and TRANSACTIONS OF THE FOURTH ANNUAL MEETING OF THE NATIONAL CONFERENCE OF GOVERNMENTAL INDUSTRIAL HYGIENISTS, Joint Meeting with the Subcommittee on Industrial Health and Medicine, Health and Medical Committee, Federal Security Agency, Washington, D. C., February 17 and 18, 1941.

Most of these may be obtained on request to the publisher or, if copies are desired for inspection, address the Committee.

From Our Notebook

An intensive twelve weeks' course in industrial hygiene and safety engineering for graduates in engineering and chemistry was started at the University of Pennsylvania on October 27, 1941.

Also a syllabus for a refresher course in industrial health, consisting of six lectures, for county medical societies or postgraduate seminars has been published by the Committee on Industrial Health of the Medical Society of the State of Pennsylvania.

The Fourth Annual Congress on Industrial Health is scheduled to be held in Chicago on January 12 and 13, 1942. The complete program has not been announced, but indications are it will be devoted in part to a thorough-going consideration of the industrial health programs of the committees on industrial health in the various state medical societies. The latest count shows thirty-eight states and the District of Columbia now have such medical society committees. Interested physicians are urged to plan in advance to attend the Congress.

Envelop Method of Treating Burns and Wounds Developed

British Navy Surgeon Devises a Covering of Watertight Silk Which Eliminates the Need of Changing Dressings

An envelop method of treating burns and wounds, introduced by Surgeon Lieutenant Commander John Bunyan, of the British navy, is described in the September 27 issue of *The Journal of the American Medical Association* by its regular London, England, correspondent. Commander Bunyan has developed a watertight silk envelop which is placed over the involved portion of the body.

"The envelop is provided with an inlet and an outlet, so that a lesion of any part may be irrigated by inserting a glass nozzle," the correspondent reports. "A simple adhesive seal is fixed to the proximal end of the envelop at the factory, so that by removing the protective gauze one produces a watertight seal by lightly pressing the adhesive to the limb and covering with an adhesive bandage."

Explaining the need for an improved method of treating burns and wounds, *The Journal* correspondent says that Commander Bunyan "holds that in the past success has been diminished by destructive antiseptics, by frequently changed dressings, painful to remove and destructive of adherent newly formed tissue, and by immobility and disuse of the part. A dressing which does not require changing is therefore desirable. It should be flexible, frictionless, bland to the tissues and transparent, so that progress may be observed. With the help of a manufacturer, envelopes of coated silk, shaped for different parts of the body, were produced. For cleansing Bunyan uses a solution of electrolytic sodium hypochlorite, because it is the least irritant.

"So far the treatment has been mainly used for burns. Applied to a first degree burn the solution immediately relieves pain, and covering with adhesive plaster is all that is necessary. Second and third degree burns are washed with the solution, the envelop is applied and the solution is run through the envelop through the outlet. This irrigation is repeated three times a day. Good results from this method are reported from the Middlesex, King's College and London hospitals. . . ."

It is pointed out that the great value of envelop irrigation is that in no case treated by it, with or without cleansing in the operating room, will anything more than mild infection occur.

SPECIAL NOTICES

SURGERY IN CHANGING WORLD THEME OF SURGEONS' 1941 CONGRESS

The pre-eminence of American surgery in a changing world, and the responsibility entailed by that international leadership, will be the theme of the thirty first annual Clinical Congress of the American College of Surgeons to be held in Boston the week of November 3. Retiring President Evarts A. Graham, M.D., of St. Louis, who is chairman of the Committee on Surgery of the National Research Council, will sound the keynote in his address, "American Surgery in a Changing World," at the Presidential Meeting and Convocation on Monday evening, November 3, in Symphony Hall. At the same session Doctor W. Edward Gallie of Toronto will be installed as president of the world's largest organization of surgeons, which now has a fellowship of more than 13,000 representing the United States, Canada, Mexico, Central and South America, and a few countries in other parts of the world.

On Tuesday evening, November 4, in the Ballroom of the Copley Plaza Hotel, the newly elected president, Doctor Gallie, will deliver the Annual Oration on Surgery. His subject will be, "Some Lessons Learned in the Great War." Doctor Gallie is Dean of the University of Toronto Faculty of Medicine and Surgeon-in-Chief of Toronto General Hospital. Two other subjects related to war surgery which will be discussed at the same session will be "The Prevention and Treatment of Tetanus" by Doctor Warfield M. Firor of Baltimore, and "The Care of the Slightly Wounded" by Doctor William Darrach of New York. On Wednesday evening in the same auditorium the guest speaker from London, Rear Admiral Gordon-Taylor, will deliver an address on "The Surgical Problems of Modern Warfare," as the opening feature of that session. Admiral Gordon-Taylor will be the official delegate from the Royal College of Surgeons to the Clinical Congress of the American College of Surgeons and has been granted a leave of absence from the Royal Navy by the British government to report to the Clinical Congress his observations on the surgical problems of the war.

Professor Alvaro of Brazil will speak on surgery of the eye at a session on ophthalmology on Tuesday evening, and Professor Mirizzi of Argentina will speak on liver and bile duct disturbances at the general scientific session on Thursday evening, November 6.

The program for the Clinical Congress includes, in addition to scientific session, panel discussions, symposia, group clinical conferences, surgical forums, and showings of medical motion pictures, an extensive schedule of clinics, exhibits and demonstrations in the three medical schools and thirty or more approved hospitals in the Boston area. Both operative and non operative clinics will be conducted by the local surgeons for the benefit of the visitors. A forum on fundamental surgical problems will be a new feature of the Clinical Congress designed to encourage younger surgeons to present before this large group their original and experimental work related to general surgery and the surgical specialties.

The twenty fourth annual Hospital Standardization Conference sponsored by the American College of Surgeons will

be held simultaneously with the Clinical Congress in Boston. The report of the 1941 Hospital Standardization survey—official announcement of the list of approved hospitals and hospitals approved for graduate training in surgery—will be presented at the opening session, on Monday morning, November 3. Among the speakers at this session will be Doctor Bert W. Caldwell of Chicago, Executive Secretary of the American Hospital Association, who will discuss "Important Legislative, Preparedness and Emergency Problems Now Facing Hospitals," and Rev. Alphonse M. Schwitalla, S. J., St. Louis, President of the Catholic Hospital Association, who will speak on "The Preservation of our Voluntary System of Hospitals." Many other prominent leaders in the hospital field will address this and succeeding general sessions, and will conduct panel discussions and round table conferences on subjects of special interest to hospital personnel. Local hospitals will hold demonstrations of administrative, technical and Hospital Standardization procedures for the visitors. The Hospital Conference will close on Thursday afternoon with a general round table discussion of practical hospital problems, which will be led by Doctor Robin C. Buerki of Philadelphia.

The concluding event of the Clinical Congress will be a special meeting of the Boston Surgical Society in Hancock Hall to which all Fellows of the College and other surgeons attending the Congress are invited. The occasion for this meeting is the presentation of the Bigelow Medal to Doctor Allen O. Whipple of New York, for his outstanding contributions to the advancement of surgery. The meeting will be on Friday evening, November 7.

A Technical Exhibition of surgical instruments and supplies, sutures, dressings, pharmaceuticals, operating room equipment of all kinds, and medical literature, will be held at the Statler Hotel as a feature of the Clinical Congress. Scientific exhibits showing College activities will be held at both the Statler and Copley-Plaza hotels and headquarters for the Congress will be established at both hotels.

NEW MEDICAL OFFICER EXAMINATION ANNOUNCED

Because of the critical need for Medical Officers in the Government, the Civil Service Commission has found it necessary to cancel the Medical Officer examination announced in August of 1940 and to issue another with certain modifications.

The principal changes in the new announcement are: the adding of the option "Public health, general" to the Senior grade and the option "Cancer: (a) Research, (b) Diagnosis and Treatment" to the Medical Officer and Associate grade; the provision for the acceptance of applications for the Associate grade from persons who have not yet completed internship; the setting back of the date of graduation for the Associate grade to May 1, 1930; and the raising of the age limit for ALL grades to FIFTY-THREE.

Further information may be obtained from the Commission's representative at any first- or second-class post office or from the Central Office at Washington, D. C.

THE FORUM

At best, evaluating a new therapeutic weapon is a hazardous job. Time has a habit of knocking the props out from under many early enthusiasms. Furthermore, quite valuable procedures are not generally acceptable due to lack of adequately trained teams and the necessary equipment, or because of a too narrow margin of safety. Occasionally, however, one does come along that is universally acceptable; and when it is a modernized version of an older one, its value is quickly demonstrated.

The intravenous use of morphine for the prompt relief of acute pain is no novelty. Enough time has elapsed to prove its efficiency and safety. Today's modification prolongs the period of relief indefinitely, and as such finds application in both medical and surgical problems. Up to the present, we have used it and seen it used for post operative pain and in the medical management of acute cholecystitis and renal colic. Our own experience with it has been most satisfactory, and our findings corroborate those of the original investigators. In post operative cases it started as soon as the patient reacts from the anesthetic; vomiting and distention are definitely diminished, urinary output is unimpeded, catheterizations are much less frequent and wound healing seems better. We have not seen any pulmonary complications or local thrombophlebitic reactions. In renal colic, passable stones have come down in quick time, painlessly and without instrumentation. It has been a valuable aid in the medical and pre operative management of acute cholecystitis both with and without a common duct stone. With a few exceptions clinical improvement was early and substantial; the result, a better prepared patient for the operative aftermath.

The technique is not difficult to follow. The dose is calculated roughly on the basis of one sixteenth of a grain of morphine per hour for the average 150 lb. adult. Our method is to add five eighths of a grain to 1000 cc. of 5% glucose in saline. The needle is then inserted into a suitable vein and the drop rate adjusted so that 100 cc. of the solution enters the circulation per hour. The depth of sedation is under complete control, for this rate can be increased or lowered to fit the individual case. The average ideal response is a quiet, dozing patient, easily aroused for questioning or necessary attention. The respiratory

rate usually stays between 12 and 16, but if it goes to 10 or below the infusion is slowed down or stopped temporarily. We have had a report reach us of its use during the first stage of labor, but in smaller dosage. If more details become available we'll be glad to pass them on.

Joe, our usually genial corner druggist, had a full head of steam up this morning. As it happened, the cause of this extremely rare phenomenon was lined up on the dispensing counter in front of him: five prescriptions calling for Tablets Sulfathiazole. Hardly justification for the steam we thought, until we looked a little closer. The fly in the ointment turned out to be that each one specified a different brand. True enough, each was a good, reliable product. What he wanted to know was why, and after we listened to his story we also wondered why. He based his case on the question of expense to the ultimate consumer, the patient. If the druggist must stock multiple brands of standard products, there is an inevitable increased overhead. Buying is restricted to the expensive smaller quantities; greater storage space is required and the time lapse in dispensing is longer. To this must be added the extra clerical work required for the handling of the orders and bills. This seemed like a fair presentation of the facts to us. Unfortunately, we couldn't give a satisfactory answer to the why. What we would like to know, is there a solution to this problem? If there is, what is it?

T. P. R., M.D.

NEWS

from County Associations

Fairfield

The Semi-Annual Meeting of the Fairfield County Medical Association was held Saturday, October 1, at the Woodway Country Club in Stamford. The membership enjoyed an address by Doctor Eugene LaForest Swan, of Brooklyn, New York, on "Emotional Problems of Children," illustrated with case reports.

Doctor Robert W. Nespor of Westport, was married last week to Miss Marion J. Sullivan also of Westport.

Gilbert E. Moore has been appointed health officer

for the town of Darien by the State Department of Health. He has been acting health officer since the death of William H. Slaughter in June, 1941.

The Stamford Medical Society held its first autumn meeting at Stamford Hall on October 14, in conjunction with the 50th anniversary of the founding of Stamford Hall. The program was headed by a paper on "The Surgical Treatment of Paralysis Agitans" by Tracy J. Putnam, professor of neurological surgery at Columbia University. Following the scientific session, the many doctors present were guests of Francis M. Shockley, physician in charge of Stamford Hall, at a most enjoyable supper.

Hartford

The annual outing of the Hartford Hospital Alumni Association was held at the Farmington Country Club on September 25. Following sports events in the afternoon, a dinner was held in the evening after which Carl Vernlund was elected President of the Association, Burwell Dodd, Secretary and B. Baylis Earle, Treasurer. In the sports events, Charles Mirabile won low putts, Maurice Root won the kickers handicap and low gross was divided between Thacher Worthen and Burwell Dodd with scores of 85. No decision was reached in the soft ball game inasmuch as the score was so large that neither side could claim to have won. The surgeons claim the score was 46 to 45 in their favor while the medicos claim it was in their favor with the same number of runs.

Litchfield

On Tuesday, October 7, the Annual Fall meeting of the Litchfield County Medical Association was held at the home of Doctor and Mrs. H. B. Hanchett at Bantam Lake. President Herbert C. Oelschlegel presided. After a short business meeting a paper was read by Doctor J. J. Derwin on a case report of sinus thrombosis cured by heparin and sulfadiazine. Doctor George M. Smith, member of the State Defense Council and Director of its Medical Preparedness Committee, discussed the latest developments in the Defense Program. There were fifty members and guests present at the meeting.

Middlesex

At the annual election of the medical board of the Middlesex Hospital held on October 8 the following physicians were elected to office: President—

Carl C. Harvey; Vice-President—William M. Joyce; Secretary—Walter Nelson.

Announcement has come from the health officer of Middlesex County that Doctor Philip Schwartz of Portland has been appointed health officer of that town.

The semi annual meeting of the Middlesex County Medical Association was held at the Edgewood Country Club in Cromwell on Thursday, October 9, which incidentally was exactly the 149th anniversary of the founding of the State Medical Society. During the scientific program Doctor David Berbi, Clinical Professor of Surgery at Tufts Medical School, spoke of "Some Surgical Problems and Their Management."

At the dinner which followed and to which wives and friends of members were invited, the speaker was Mr. Robert C. Deming of Hartford. He spoke on the present status of civilian defense.

It was announced during the meeting that the sesquicentennial celebration of the State Society will be held at Wesleyan University in Middletown during June, 1942.

The Central Medical Society held its first meeting of the new season at Bengston Wood Hall in Middletown, October 13. Doctor Max Taffel of the Department of Surgery, Yale School of Medicine, spoke on "Certain Aspects of War Surgery."

Doctor Benjamin Simon of the Worcester State Hospital has been appointed clinical director at the Connecticut State Hospital in Middletown. The appointment was made from a list presented by the office of the Connecticut State Merit System. Doctor Simon received his bachelor of arts degree from Stanford University in 1925 and his master of arts degree in 1927. He was graduated from the Washington University Medical School in 1931. He has been on the staff of the Worcester State Hospital since 1934 and will report here about November 1, 1941.

Doctor Alexander J. Mozzer of the staff of the Connecticut State Hospital has been elected to membership in the New England Psychiatric Association.

Doctor Roy L. Leak, Superintendent of the Connecticut State Hospital, has stated that there is a definite increase of late in the number of alcoholic and senile patients admitted to the hospital. A cafeteria system inaugurated for patients at the hospital is proving quite successful and it is thought the plan will be a saving both in labor and in food.

Doctor James Murphy of Middletown has been re-elected president of the Middletown Department of Health.

Doctor F. Erwin Tracy of Middletown was recently enrolled in a postgraduate course at the College of Physicians and Surgeons, Columbia University, New York City.

Doctor Mario L. Palmieri, health officer of the City of Middletown, has carefully checked for possible sources of infection in recent cases of anterior poliomyelitis occurring here and presents the data on two cases showing a definite history of contact:

The H. sisters, aged 11 and 10 respectively, returned to Middletown from a five weeks' vacation in Vermont and Massachusetts on August 23, 1941. Six days later, August 29, 1941, both developed a mild illness characterized by headache, temperature and muscular aches and weakness most marked in the lower extremities. With the simple treatment of bed rest both recovered uneventfully in four days. Medical aid was not summoned because of the mildness of the episode.

S. H., a 12 year old girl neighbor, returned from a summer camp on August 25, 1941, and spent a good deal of time with her playmates, the H. sisters, during the four days prior to their undiagnosed illness. On September 1, 1941, S. H. helped her mother in the preparation of salad sandwiches of tuna fish, crab meat and egg for a picnic, and she together with her parents and younger sister went back to the summer camp for that day. That evening a few sandwiches were left over and A. G., 19, a swimming instructor at the camp, was invited to have some. He ate heartily, and a roommate of his had no sandwiches but had a banana and some milk with him.

On September 9, 1941, S. H. developed symptoms and signs which pointed to a diagnosis of paralytic poliomyelitis. A period of ten days had elapsed from the time of the last exposure to the H. sisters before the onset of symptoms.

On September 14, 1941, A. G., who had eaten sandwiches prepared by S. H. on September 1, 1941, became ill and a diagnosis of paralytic poliomyelitis was made. His roommate who had been similarly exposed to S. H. in every way with the exception of the food prepared by her did not become ill. The interval between exposure and development of symptoms was 13 days.

The association between these cases was based entirely on the history. It is regrettable that no

simple laboratory technique is available to make a complete study of cases and contacts in poliomyelitis.

New London

The semi annual meeting of the New London County Medical Association was held at Uncas-on-Thames, Norwich, October 2. The business meeting was called to order at 4:30 P. M. by President Hugh F. Lena of New London, with fifty members and guests present. The guests were: President of the State Medical Society, James D. Gold of Bridgeport, Secretary of the State Society, Creighton Barker, President of the State Council, James R. Miller of Hartford, and G. M. Smith of Pine Orchard, Chairman of the State Medical Society Committee on Medical Defense.

Following the business meeting an excellent dinner was served to the members and guests by Hugh B. Campbell, Superintendent of Uncas-on-Thames, and his staff. The scientific meeting was called to order at 8:30 P. M. The program featured a discussion of "Intestinal Obstruction" by Doctor Irving J. Walker of Boston, visiting physician to the Boston City Hospital, who presented the surgical aspect of the subject in an interesting manner. The medical aspect was very ably handled by Doctor Franklin W. White of Boston, visiting physician to the Boston City Hospital. The papers were well received as evidenced by the long period of discussion which followed.

The medical profession of New London was surprised last month by receiving tax bills from the New London Tax Collector on their office equipment. This is the first time in the memory of any of the local physicians that they were taxed on their office equipment.

(New London physicians have been lucky. Hartford has enjoyed this practice for many years.—Editor.)

News from Yale University School of Medicine

Doctor Edgar Allen Honored

Prof. Edgar Allen, Chairman of the Department of Anatomy of the Yale School of Medicine, has

been signally honored by the Royal College of Physicians of London with the award of the Baly Medal.

The medal was awarded to the Yale anatomist for his work on estrogens, or female sex hormones, on the recommendation of Sir Charles Wilson, president, and the Council of the Royal College. It is conferred every two years by the college for research in physiology.

Previous recipients of the medal in recent years include: Prof. E. L. Kennaway, of London, for his identification of carcinogenic hydrocarbons, or coal tar derivatives which produce cancer, awarded in 1937; and Prof. C. H. Best, of Toronto, in 1939, one of the Canadian physiologists who isolated insulin from the pancreas, and recently has purified heparin, an extract of the liver which prevents clots forming in the blood vessels.

Prof. Allen, working in collaboration with Prof. Edward A. Doisy, of St. Louis University, was the first to extract the female sex hormone from the ovarian follicles. This hormone is believed to be primarily responsible for cyclic function of the repro-

ductive organs and for secondary sex characteristics.

In recent years he has been working on the effect of sex hormones on cancer of the uterus in experimental animals. This has been done at Yale in collaboration with Doctors W. U. Gardner, G. M. Smith, L. C. Strong and others. He has also edited and contributed chapters to "Sex and Internal Secretions," an encyclopedic work which has become a standard medical reference.

An English announcement of the Baly Medal award states that Doctor Allen's "contributions to the subject form an essential foundation to modern knowledge of the endocrine action of the ovaries."

Graduating from Brown University in 1915, Prof. Allen received an A.M. and Ph.D. degrees from the same institution, and in 1936 was given an honorary degree of Doctor of Science. He was an instructor and associate in anatomy at the Washington University, St. Louis, from 1919-1923. From 1923 to 1933 he was professor of anatomy at the University of Missouri, and Dean of the School of Medicine for five years. He has been a Professor of Anatomy at Yale University School of Medicine since 1933.

OBITUARY

William Henry Gray, M.D.

1862 - 1941

On July 17, 1941, death came to Doctor William Henry Gray of Mystic, one of the oldest and most respected members of the New London County Medical Association. Death was due to cerebral hemorrhage following a long period of impaired health.

William H. Gray was born in North Stonington, in New London County, September 16, 1862. He was the son of William and Sarah Richardson Gray. Above the average in intelligence and ambition, he sought a professional education and entered the Mystic Valley Institute to prepare for college. He was graduated from there in 1885 and entered the College of Physician and Surgeons of New York, graduating with the class of 1889. He began practice in Old Mystic in association for the first two years with Doctor Albert T. Chapman. In 1898 he moved to Mystic where he carried on an active practice until his retirement. Despite the difficulties and handicaps of a country practice in those horse and buggy days, he kept fully abreast of medical

advance in his knowledge and skill and always maintained a high standard of ethical loyalty toward his fellow practitioners.

During the World War Doctor Gray served at first as the physician member of the draft board for the Twentieth Senatorial District and then, notwithstanding his fifty six years, sought active service and was commissioned Captain in the Medical Corps of the United States Army where he served until the end of war.

He was member of the Connecticut State Medical Society and the American Medical Association and held membership in the New London County Medical Association since 1895. He was a member of the consulting staff of the Home Memorial Hospital, New London, and for several years was Medical Examiner for the Town of Stonington. He was a member of the American Legion and was the first commander of Richard Morgan Post of Mystic.

Doctor Gray married Mary Ida Barnes of Old Mystic. Mrs. Gray died in 1929 and from that time the doctor gradually gave up his professional activities. He is survived by three daughters: Mrs. Eric Bradley and Mrs. William Browning, both of Washington, D. C., and Mrs. Edward Bradley of Stonington in whose home he lived during his last days.

"No one comes so near the gods as one who shows protection and kindness to men." Seneca.

CONNECTICUT CLINICAL CONGRESS 1941

Paid Registrations	672	88.7%	Percentage of Members of Fairfield County Society Who Registered	21.2%
Free Registrations	86	11.3%	Percentage of Members of Tolland County Society Who Registered	14.3%
Total Registrations	758		Number of Registrants from Connecticut who had also attended the 1940 Clinical Congress	371 55.9%
From Connecticut	664	87.6%	Number of Registrants from Connecticut who did not attend the 1940 Clinical Congress but who had attended previous Clinical Congresses	152 22.9%
From New Haven County	311	41.0%	Number of Registrants from Connecticut who were new this year	141 21.2%
From Hartford County	139	18.3%	Number of Registrants from Outside of State who had attended the 1940 Congress	18 19.2%
From Fairfield County	105	13.9%	Number of Registrants from Outside of State who had not attended the 1940 Congress but had attended previous Congresses	19 20.2%
From New London County	39	5.2%	Number of Registrants from Outside of State who were new this year	57 60.6%
From Middlesex County	28	3.7%	Total Number of Registrants who had also attended the 1940 Clinical Congress	389 51.3%
From Litchfield County	23	3.0%	Total Number of Registrants who did not attend the 1940 Clinical Congress but who attended previous Clinical Congresses	171 22.6%
From Windham County	16	2.1%	Total Number of Registrants who were new this year	198 26.1%
From Tolland County	3	0.4%	60% of the 1940 Registrants from Connecticut returned in 1941.	
From Outside of State	94	12.4%	21.7% of the 1940 Registrants from Outside of State returned in 1941.	
From New York	33	4.35%	55.6% of 1940 Total Registrants returned in 1941.	
From Massachusetts	26	3.43%	Number of Registrants who also registered for the special course in Traumatic Surgery	143 21.3%
From Rhode Island	15	1.97%	(Note: This percentage is based on the paid registrations as all these came from that group.)	
From New Jersey	5	.66%		
From Maine	5	.66%		
From New Hampshire	3	.40%		
From Maryland	2	.27%		
From Indiana	2	.27%		
From Pennsylvania	1	.13%		
From Florida	1	.13%		
From Texas	1	.13%		
Members of the Conn. State Society	536	70.7%		
Percentage of Members of the State Society Who Registered		29.4%		
Percentage of Members of New Haven County Society Who Registered		43.5%		
Percentage of Members of Windham County Society Who Registered		36.6%		
Percentage of Members of Middlesex County Society Who Registered		32.4%		
Percentage of Members of New London County Society Who Registered		27.5%		
Percentage of Members of Litchfield County Society Who Registered		24.4%		
Percentage of Members of Hartford County Society Who Registered		22.7%		

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PRINCIPLES AND RECOMMENDATIONS FORMULATED BY JOINT CONFERENCE COMMITTEE OF CONNECTICUT PHARMACEUTICAL ASSOCIATION AND CONNECTICUT STATE MEDICAL SOCIETY

These Principles and Recommendations were accepted by the Connecticut Pharmaceutical Association soon after their formulation. They have now been approved by the Council of the Connecticut State Medical Society and will be submitted to the House of Delegates for consideration at its next meeting on December 10.

STANLEY B. WELD

Chairman, Joint Conference Committee

1. The use of prescription blanks bearing a pharmacist's name is bound to be misunderstood and has no justification whatever. We recommend that the Connecticut State Medical Society adopt a policy urging physicians to use blank prescription forms.

2. A physician owes it to his patient to be sure that his prescription will be filled accurately and completely. It is proper for the physician to recommend pharmacies when on inquiry he finds that his prescription is to be placed in a pharmacy in which he has no confidence. If this practice is followed it will aid the pharmaceutical profession in maintaining the highest standards of service and gradually eliminating the incompetent and unscrupulous pharmacists.

3. U. S. P. and N. F. preparations should be prescribed whenever possible. This will require a diligent campaign of education among the members of the medical profession that will reduce dangerous self medication, incorrect dosage, and mistakes in purchasing drugs.

4. Counter prescribing as your Committee understands it is illegal, unethical, and improper. Counter prescribing represents the actual involvement of a diagnosis. It is one of the evils that can be controlled only by the coöperative efforts of both physician and pharmacist. We recommend that the pharmacists known to practice counter prescribing be discredited by the medical profession and by organized pharmacy.

5. Dispensing of drugs by physicians is carried on to an unjustifiable extent in some localities. Local conditions in certain places make a limited amount of such dispensing necessary, but this always should be limited in quantity to prevent infringement upon the function of the pharmacist. Above all, the practice of dispensing samples by physicians should be condemned. If a sample must be dispensed the physician should remove it from the original container or,

when this is impracticable, remove all trace of the original inscriptions and affix thereto his own directions to his patient.

6. Physicians are careless in not marking prescriptions "non repetative" or "N. R." unless such prescriptions are to be filled indefinitely. We recommend that pharmacists be urged to communicate with a physician whenever his patient presents a prescription for refilling more than a few times. This is very important in the case of certain drugs.

7. Physicians should not give their patients the name of a proprietary medicine when prescribing the same, and whenever possible should use the Latin or chemical name. This will help to minimize self medication.

8. Physicians are often thoughtless in not properly explaining the purpose of prescriptions to their patients. The pharmacist will not be embarrassed by having to refuse to answer patients' questions about prescriptions if physicians attend to this obligation.

9. Physicians should not expect pharmacists to execute narcotic prescriptions unless the former has fulfilled his legal responsibility in writing them in accordance with the law. We recommend that pharmacists refuse to fill such prescriptions when the requirements of the law are not met.

10. A physician should not attempt to estimate the likely cost of a prescription. It is unfair to the pharmacist and is comparable to the pharmacist attempting to prejudge a physician's fee. It is advisable, however, that when a drug prescribed is known to be expensive the patient should be so advised.

11. There are still some unscrupulous druggists who treat venereal disease. It is recommended that physicians report to the State Pharmacy Commission any such practice which may come to their attention.

12. We very emphatically condemn the too prevalent practice existing in many towns and cities of this State whereby pharmacists offer and mem-

bers of physicians and surgeons groups accept a gratuity in cash and/or merchandise from said pharmacists for their prescription work. This insidious unethical practice on the part of pharmacists and physicians alike adds to the cost of medical attention and patient's medication in times of stress and is done to create a monopoly of the prescription business often times at the expense of the patient and to create an appearance of great volume of business and accorded prestige in the various communities.

New Physiotherapy Technician Examining Board

On September 17, at the Union League Club in New Haven, the newly appointed board of examiners for physiotherapy technicians met and organized. Doctor Joseph A. Beauchemin, Pathologist at the State Hospital in Middletown, was elected President and Doctor D. S. O'Connor, of New Haven, was elected Secretary and Treasurer.

It was the sentiment of the board that every effort should be made to bring to the attention of the physicians of the state, the existence of this law so that eligible technicians may avail themselves of the opportunity to be registered without examination.

Section 2 of "An Act Concerning The Practice of Physiotherapy by Technicians" states that for qualification for registration, without examination, each person shall prove:

1. That he is a citizen of the United States or has legally declared his intention of becoming one.
2. That he has practiced physiotherapy as a technician in a hospital, sanatorium or clinic approved by the State Department of Health, has taught this subject in a school or junior college of physiotherapy approved by the State Board of Education or has been regularly employed by a physician in such capacity prior to July 1, 1940.

The board hopes to be able to consider applications soon.

Why Join the Red Cross



All Red Cross activities today are in process of expansion. The growth of our Army and Navy and the intensification of defense production have made heavy demands on the organization. First aid detachments are being organized and trained for defense industries; at Army and Navy posts and military and naval hospitals are trained Red Cross representatives to conduct welfare work and morale maintaining activities among the men in the service; in local chapters volunteers are carrying on, teaching home nursing and nutrition, producing surgical dressings and garments, and conducting many other activities.

All this work is supported from annual membership dues, and occasional voluntary contributions and gifts. Because of the great expansion of Red Cross work this past year millions of new members are needed. Everyone is urged and invited to join a local Red Cross chapter during the membership Roll Call, November 11-30.

Doctor La Moure Retires

On July 1 Doctor Charles T. La Moure, genial councilor from Tolland County, retired from his position as Superintendent of the Mansfield State Training School and Hospital. He is now at home to his many friends in Windham, Connecticut.

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War Medicine, Vol. I, No. 5

The latest number of the American Medical Association's most recent publication, *War Medicine*, contains much valuable information. The first three articles are of particular interest. Doctor Robert E. Plunkett, General Superintendent of Tuberculosis Hospitals, New York State Department of Health, presents the experiences to date with the various aspects of tuberculosis in men of selective service age. Colonel Edgar E. Hume, Medical Corps, U. S. Army, affords the reader an excellent article, well illustrated, on "Training of Medical Officers for War Duty," and Captain Lucius W. Johnson, Medical Corps, U. S. Navy, presents an interesting "Experiment in Hospital Mobility." In addition to these are several articles dealing with subjects related to the present emergency, as well as with original experimental work such as a report on the action of sulfanilamide in the treatment of gas gangrene. The text of President Roosevelt's appointment of Mr. Paul V. McNutt as Director of the Office of Defense Health and Welfare Services is included in this issue and there are thirty pages of abstracts from current literature on war problems.

Hygiene and Public Health, founded at Johns Hopkins shortly before the close of World War I. The first scientific medical magazine in this country boasted him as its editor. Finally, as Professor of the History of Medicine, at Johns Hopkins, he made a major contribution to medicine unsurpassed in its kind by any individual of recent years.

The book is attractively bound, with many interesting illustrations. Text notes and source references for each chapter fill many pages in the appendix.

This intimate picture of one of Connecticut's greatest leaders of science, will take its place among such companions as Cushing's Life of Sir William Osler, Vallery-Radot's Life of Pasteur, and Eve Curie's biography of her mother, Madame Marie.

SULFANILAMIDE AND RELATED COMPOUNDS IN GENERAL PRACTICE. By Wesley W. Spink, M.D., Associate Professor of Medicine, University of Minnesota Medical School. Chicago, Illinois: The Year Book Publishers, Inc. 1941. 256 pp. Illustrated. \$3.00.

Reviewed by WILSON FITCH SMITH

During the past few years most spectacular advances have been made in the field of chemotherapy. So rapidly have improvements followed one upon the other, that no sooner are we feeling familiar with one member of the sulfonamide family than a new member appears and threatens to overshadow in popularity its predecessors. There have been, moreover, a few serious incidents accompanying the too enthusiastic acceptance of what at first appeared to be a panacea for all human ills. We are confused by hundreds of reports in the scientific literature, many of them conflicting in conclusions or with incomplete data. In the midst of this exciting confusion there now appears a small and concise book to serve as a reliable guide to all practitioners.

This little book of only 220 pages of text presents in a simplified and practical manner the conclusions that an experienced clinician has drawn not only from the review of the vast accumulated literature, but also from a large personal experience at the University of Minnesota Hospitals. Although in some purely theoretical aspects he leaves the question unanswered, on most controversial subjects Doctor Spink gives a concise statement of fact based on his personal observations.

The emphasis is on clinical application with simplified dosage and useful hints as to actual modes of administration. There are several clear and practical tables showing "Preferential Use of Sulfonamide Compounds" and possible "Toxic Manifestations," which in themselves are very useful. There are also carefully chosen illustrative case reports that add interest to the text. The background of the necessary bacteriology and chemistry is simple and easy to grasp. There are even included chapters on the recently released compounds, sulfaguanidine and sulfadiazine. Finally, there is an excellent bibliography 25 pages long.

Because of the meteoric progress of chemotherapy this text undoubtedly will soon become outdated, but for the present it offers the latest opinion on the subject and will be of great help to any doctor who is using this powerful weapon in combating infection.

NEW BOOKS IN REVIEW

WILLIAM HENRY WELCH AND THE HEROIC AGE OF AMERICAN MEDICINE. By Simon Flexner and James Thomas Flexner. New York: The Viking Press. 1941. 539 pp. \$3.75.

Reviewed by STANLEY B. WELD

William Henry Welch, born and reared among the Connecticut hills at Norfolk, still lives in the memory of many physicians of his native state as the dean of American medicine. This is a particularly fitting time to pay tribute to this remarkable genius, the son of a country doctor, since in a few months Connecticut physicians will gather at Middletown to celebrate the sesquicentennial of their Society. Doctor Simon Flexner, a pupil and associate of Doctor Welch, and his son James Flexner have supplied a wealth of material secured from a great variety of sources. Much of the information comes first hand from Doctor Welch's diary.

This volume, written as a biography is more than this as it presents a valuable picture of the progress of medicine in the United States during the latter half of the nineteenth and the early twentieth centuries. Doctor William Henry Welch was a character of international fame. To him goes the credit for founding the first pathological laboratory in the United States. To his genius is due the success of the School of

ESSENTIALS OF DERMATOLOGY. By *Norman Tobias*, M.D., Senior Instructor in Dermatology, St. Louis University, St. Louis. Philadelphia, Montreal and London: J. B. Lippincott Company. 1941. Cloth. 497 pp. with 143 illustrations. \$4.75.

Reviewed by F. EARLE KUNKEL

This is a brief handy volume on diseases of the skin primarily for general practitioners and medical students. The newer concepts of dermatology have been incorporated in the book. Differential diagnosis has been stressed and diagnostic features emphasized. The writer has attempted, so far as practical, to discuss each disease from the standpoint of internal medicine. Forty five pages are devoted to syphilis. The illustrations are of good quality. The author's style of writing is simple, practical and very interesting. The book should be exceedingly useful to those engaged in the general practice of medicine and the student should be able to absorb easily a considerable number of the basic facts of dermatology. It is recommended as an excellent synopsis on dermatology.

PROCTOLOGY FOR THE GENERAL PRACTITIONER. By *Frederick C. Smith*, M.D., M.S.C. (Med.); F.A.P.S. Formerly Associate in Proctology, Graduate of Medicine, University of Pennsylvania; Fellow, American Proctologic Society; Editor, The Weekly Roster and Medical Digest, Philadelphia County Medical Society; Editor, The Medical World; Lieutenant Colonel, Medical Reserve Corps, United States Army. Philadelphia: F. A. Davis Company. 1941. 466 pp. 161 illustrations. \$4.50.

Reviewed by ANDREW TAYLOR

"If this book helps the general practitioner in his treatment of ano-rectal conditions, the author will feel well repaid for his efforts in producing it." These are the words of the concluding sentence of Doctor Smith's preface to the first edition.

This purpose has been well carried out in his presentation of a highly specialized and greatly neglected field. Emphasis, throughout, is placed on the need of careful examination in patients presenting themselves with ano-rectal symptoms instead of the casual administration of suppositories or ointments without the necessary and important inspection of the offending area.

The opening chapter is a handy reference within itself for the general practitioner who has analyzed the patient's symptoms and is in need of leads for diagnosis. A discussion of stool examination is new to this edition. The chapters on embryology and anatomy and malformations of the anus and rectum present nothing new. Next, a chapter on examination and diagnosis again emphasizes the theme of thoroughness in taking a careful history and making a minute examination before attempting treatment.

Then follows the various chapter headings taking the reader through the entire field of ano-rectal diseases in easily understandable language and without presenting too many forms of treatment to confuse the reader who may be seeking advice for the treatment of a case at hand.

Doctor Smith has added a discussion of pectenosis (pp. 151-152 and 272); a discussion of valves of the pelvis veins as a factor in hemorrhoid formation (pp. 174-175); the ligature and excision operative technique for hemorrhoidectomy (pp. 190-203); further suggestions for the treatment of pruritus ani (pp. 240-247); new suggestions for the eradication of *Entamoeba histolytica* (pp. 306-309); a new section, discussing granuloma inguinale, in contradistinction to lymphogranuloma venereum (pp. 335-336); descriptions of *Balanitidum*, *Schistosoma*, *Trichomona* and *Giardia* in his chapter on parasites (pp. 358; 359; 360; 361); an interesting table on the etiology of diarrhoea (pp. 391-393); a section on the grading of malignancies (pp. 409-411); and, as is indicated, an enlarged table of contents and index which is carefully and minutely detailed.

Certainly the author has lived up to his purpose and has kept it "a guide for the general practitioner." To this group it is especially recommended. Other groups could refresh themselves with the fundamentals and some of the newer refinements which are presented.

THE MASK OF SANITY. (1st edition.) By *Hervey Cleckley*, B.S., B.A. (Oxon.), M.D. Professor of Neuropsychiatry, University of Georgia, School of Medicine, Augusta, Ga. St. Louis: The C. V. Mosby Co. 1941. pp. 298. \$3.00.

Reviewed by GEORGE A. GOSSELIN

The rather intriguing title of this book loses none of this quality in the reading of it.

Doctor Cleckley has attacked a real problem in neuropsychiatry, one about which volumes, so to speak, have been written. Much of the literature on the subject lacks concreteness and simplicity. The author of the "Mask of Sanity" cannot be so accused.

Doctor Cleckley approaches the subject matter with case histories elaborated in an interesting and arresting style and then makes a fine effort at interpretation of the psychopathic state. Its relationship to the psychoses, to the "man of the world," to the "physician," to the "scientist" and to the "psychiatrist" are interpreted in a relevant, practical and at times an amusing manner.

Aside from the discussion of the psychopathic personality, probably the greatest contribution one finds in this small volume is the distinction which the author makes between this state and other common types of personality disorders. The latter group, next to the psychopath, is a fruitful source of the proverbial headache to the neuropsychiatrist who is

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placed in the position of having to do something about a situation with wide sociological implications. The authorities and sociologists want more specific answers to medicolegal problems encountered in these cases. A thorough reading of Doctor Cleckley's analyses certainly offers a better understanding of the basic etiological factors and the motives behind these behavior patterns.

The author's suggestion for, "What Can be Done," the final chapter, are worthy of note. There is an idealism about them which, with a note of humor, impresses a reader with the fact that there may be a ray of hope in what he has to offer.

Doctor Cleckley's bibliographic references are not too extensive, but quotations from them are to the point. There is an easy flowing simple style throughout the volume making it one of the best of its kind.

A MANUAL OF BANDAGING, SPLINTING AND STRAPPING. By Augustus Thorndike, Jr., M.D., F.A.C.S., Associate in Surgery, Harvard Medical School; Surgeon to the Department of Hygiene; Harvard University. Philadelphia: Lea & Febiger. 1941. 144 pp. 117 engravings. \$1.50.

Reviewed by EDWARD H. CROSBY

The outstanding feature of this little book is the well chosen, descriptive pictures. Bandaging, in all its phases for all parts of the body, is described in a systematic method and adequately illustrated. Many unique methods of applying the roller bandage, the triangular bandage and the plaster bandage are outlined with diagrams. Splinting, both with and without traction, is so well handled that this book should be studied by all hospital interns. This book is to be recommended to every nurse, medical student, interne and practicing physician.

CARDIAC CLASSICS. By Frederick A. Willins, M.D., M.S., in Medicine Chief, Section of Cardiology, The Mayo Clinic; and Thomas E. Keys, A.B., M.A., Reference Librarian, The Mayo Clinic. St. Louis: C. V. Mosby Co. 1941.

Reviewed by PAUL H. TWADDLE

In this handsome volume of 858 pages are collected articles of special interest, which have been milestones in the development of present day cardiology. Fifty two contributions by fifty one authors are included and arranged in chronological order. A biographical account of the author prefaces his contribution and in most instances portraits are reproduced. The volume contains reproductions of many of the interesting, original sketches and diagrams.

Because of the mass of literature pertaining to cardiology, it has been impossible to include all articles which might be considered of fundamental importance. Those chosen are ones which the authors considered of greatest interest. The first Classic is "An Anatomical Disquisition of the Motion of the Heart and Blood in Animals," by William Harvey, published in 1628, and the final article is Doctor J. B. Herricks' account of coronary thrombosis, 1912. More recent contributions have been purposely omitted, despite their admitted historical value. The articles included deal with anatomy and physiology of the heart, description of heart disease, pathol-

ogy, therapeutics, etc., while its authors include names such as Withering, Laennec, Flint, Roger, Steele, Aschoff, Osler, etc.

The value of such a book to those interested in cardiology is obvious. Besides being a ready source of reference to the key articles pertaining to the heart, it should also serve as a stimulus in its emphasis of the value of accurate and thorough observation.

DOC'S WIFE. By Faye Cashatt Lewis, M.D. New York: Macmillan Company. 1940. 198 pp. \$2.00.

Reviewed by ANOTHER Doc's WIFE

"Doc's Wife" is an account of the early experiences of a young couple in establishing a practice in Iowa, but might as easily have been written in any other hundred or more small communities in any other State. In the hands of a more imaginative or gifted writer the pages might have contained a certain amount of local color and subtle humor. As they now stand the many personal anecdotes belong solely in the author's Five Year Diary and the too numerous case reports should remain in the files of her doctor-husband's office. An unwritten code of ethics would prohibit us from pinning up in full public view any similar array of dingy linen.

THE STORY OF CLINICAL PULMONARY TUBERCULOSIS By Lawrason Brown, Late director of Trudeau Sanatorium and Lecturer in Trudeau School of Tuberculosis 1871-1937. Baltimore: Williams & Wilkins Co. 1941. 411 pp. \$2.75.

Reviewed by CLARENCE L. ROBBINS

There can be no dispute of the right of Doctor Brown, whose lectures on the history of tuberculosis in the Trudeau School of Tuberculosis comprise the major part of this posthumous volume, to the "apostolic succession" of Louis, Laennec's pupil, who began an illustrious line of contributors to the early diagnosis of pulmonary tuberculosis. With his most critical colleagues, as with his legion patients "Lawry" Brown's opinion was law because behind it was a vast store of knowledge and experience. His familiarity with the historical beginnings of the diagnostic techniques that every medical graduate of today must learn to employ contributed largely to his own mastery of those techniques. His book records only in part what he must have known and felt about the minds and personalities of his predecessors.

Nevertheless, the book is still too rich for ordinary digestion. One can sense the effect of finished brilliance that must have been left in the minds of his audience when the individual lectures were given. End on end, they are repetitious and give a feeling of confusion. Despite the advice in the preface that repetitious matter where periods overlap has been eliminated as far as possible, the reader finds himself wishing the blue pencil had been wielded far more freely. A case in point is the chapter entitled "The Visit in 1800" which begins with a scholarly orientation as to the condition of science, society and general medicine in the early nineteenth century, proceeds to a delightful written biography of Napoleon's private physician, Corvisart, then describes a truly fascinating visit with Doctor Gaspard Bayle to a physical patient at the Charité Hospital. The transition to a review of the life and contributions of Auenbrugger, dis-

coverer of percussion, is sheer good writing. "Auenbrugger was the first to blaze the trail that was to lead out of the confusing wilderness of symptoms toward the diagnosis of chest affections. Vienna has produced nothing equal to it. It was the beginning of modern diagnosis. He knocked on the chest, and the door of diagnosis flew open—but he listened with his mind." Unhappily, the editors saw fit to conclude "The Visit in 1800" with eight pages of historical data, much of which could be of interest only to a student of the history of percussion.

The chapters on Diagnosis by X-rays written by Doctor Homer L. Sampson and on the Development of Surgical Methods in Treatment by Doctor Edward W. Archibald are richly informative, well organized and skillfully written. Doctor Archibald says "it was, nevertheless, Lawrason Brown, of Saranac Lake, who in America sent the first patient for thoracoplasty to a surgeon as the beginning of a definite therapeutic policy, using a new weapon in a planned purposeful way in the fight against tuberculosis. His wide reading, which included French and German publications, gave him the groundwork of knowledge already acquired; upon which basis he was convinced that the operation was sound in principle, and that success could be expected if the cases were carefully selected."

The book is recommended for at least partial reading by every student of tuberculosis, of medical history, and of physical diagnosis—which would seem to include just about every one studying and practicing medicine.

THE PHARMACOLOGY OF ANESTHETIC DRUGS:
A Syllabus for Students and Clinicians. (2nd edition.)
By *John Adriani, M.D.*, Instructor in Anesthesia, New York University College of Medicine. *Springfield, Illinois:* Charles C. Thomas. 1941. Cloth. Pp. 86 with illustrations. \$3.50.

Reviewed by A. W. FRIEND and R. M. TOVELL

To those unfamiliar with the first edition of this book it should be said that it is a compendium and a compilation wherein the author, by means of a diagrammatic arrangement of the subject matter, focuses attention on the prime physiological and pathological changes that occur in various organs and systems as a result of the use of anesthetic agents. Several new chapters have been added in this edition and they have augmented greatly the value of the book. Outstanding is the

one on Disturbances of Respiration in which numerous facts and details of fundamental importance to the anesthetist are clearly presented. Each anesthetic agent is discussed concisely and pointedly.

These reviewers, being interested in obstetrics and obstetrical anesthesia, found the discussion of the effects of cyclopropane on the uterus interesting. It is pointed out that contractions are not decreased in light anesthesia, that they are abolished only when the patient has been anesthetized to the 3rd plane of the 3rd stage; that the concentration in the fetal blood equals that in the maternal blood in fifteen minutes of anesthesia and that the oxygen content of the fetal blood is decreased approximately 20%.

In an original article by the author on the Stability of Vinyl Ether (Vinethene) which appeared in "Anesthesiology" for March, 1941, he reported that "Vinyl Ether, once opened, may be sealed by replacing the cap, and the remaining portion may be used within a period of ten days without fear of deterioration." From the point of view of cost of this drug it is unfortunate that he did not have this information when this book was being prepared, for in it he states that "an opened bottle should be discarded after 12 hours."

Under Administration of Chloroform it is stated that "high oxygen with closed system protects against liver damage." One wonders if it might have been a little more conservative to state that "high oxygen . . . mitigates hepatic damage."

In discussing the administration of an ultra-short-acting barbiturate, the author states that "cumulative action forbids repeated dose." Again, under Thiobarbital (Pentothal) he states that "cumulative action results from successive administration." Here one is forced to disagree with him. The only time when there might be an *apparent* cumulative action is when there is impairment of the mechanism of detoxication. These reviewers have in mind a patient to whom pentothal has been administered twenty times over a period of six months in doses ranging from 0.5 gram to 1.5 gram and at no time has there been any clinical evidence of a cumulative effect.

There is a new section on Some Clinical Considerations which is of value to the clinician and anesthetist. Among other topics are included Pre-Anesthetic Medication, Carbon Dioxide Absorption, Complications and Accidents During Anesthesia, Post-Anesthetic Sequelae, Anesthesia and Respiratory Complications, Fires and Explosions, Glossary, various tables, and a comprehensive list of references. In the list of

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conversion factors one thinks it might have been worth while to include the kilogram.

The binding of this second edition is excellent. The format is good. In the entire book only four mistakes in spelling were found and obviously these were typographical errors. One recommends this book highly as a handy reference for anesthetists, for clinicians interested in factors governing choice of anesthetic agent and method, and for research workers.

PHYSICAL MEDICINE: THE EMPLOYMENT OF PHYSICAL AGENTS FOR DIAGNOSIS AND THERAPY. By Frank H. Krusen, M.D., F.A.C.P. Associate Professor of Physical Medicine, the Mayo Foundation, University of Minnesota. Philadelphia: W. B. Saunders Company. 1941. 846 pp. 351 illustrations. \$10.00.

Reviewed by ALEXANDER L. BASSIN

Doctor Krusen has prepared a most comprehensive, modern work upon Physical Medicine which clarifies without redundant details the many valuable uses of physical therapeutic agents. The text is arranged effectively for prompt and easy reference and is illustrated copiously. The photographs and line drawings are reproduced sharply and explained clearly. The text is composed skilfully and interpretations of reference work have been treated expertly. The author, who is eminently familiar with his subject, has divided the book into nine major sections, each dealing with a phase of Physical Medicine, as, for example, Light Therapy, Hydrotherapy, Mechanotherapy, etc. The chapter on the history of Physical Therapy will impress the reader with the author's



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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," *Am. J. Syph., Gon. & Ven. Dis.*, 23, 201 (March), 1939.

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scholarly comprehension of the development of this important field of therapeutics from the time even before 7000 B. C., when the cave man turned the sunlight to his aid in healing, through the more recent period of Granger and Tait and their influence upon the advances in physical therapeutic methods. The chapters included in the various sections have been developed in an orderly manner and the basic principles of physiology, mechanics, and physics treated carefully and clearly. The application of these various modalities is described fully and with definite attention toward the practical and successful use. For example, the fundamental concepts for the use of heat and light and the explanation of the proper application of these agents have been developed in detail. A significant discussion is made of the limitations and utility of Electrotherapy. The section dealing with Hydrotherapy also will provide additional confirmation of the completeness and usefulness of this book. The misconceptions concerning the effectiveness of massage and mechanical aids in treatment of disease will be dispelled in the sections dealing with the review and analysis of these therapeutic modalities. The author has selected studiously from a voluminous literature an excellent bibliography which is added to the corresponding chapter.

This book will broaden the experience of both the physician and the student by providing an added incentive for the accurate application of the often unused and at times abused valuable therapeutic agents.

ABDOMINAL SURGERY OF INFANCY AND CHILDHOOD. By William E. Ladd, M.D., F.A.C.S., Professor of Child Surgery at Harvard Medical School; Chief of Surgical Service, The Children's Hospital, Boston, and Robert E. Gross, M.D., Associate in Surgery, The Harvard Medical School; Associate Visiting Surgeon, The Children's Hospital; Associate in Surgery, The Peter Bent Brigham Hospital, Boston. Philadelphia: W. B. Saunders Company. 1941. 440 pp. \$10.00.

Reviewed by BURWELL DODD

The authors have gathered their material and formed their statistical tables from The Children's Hospital of Boston over the past twenty-five years. Therefore, we have the experiences and results of men specialized in this field of surgery over a long period and with careful and complete follow up data. While references to the literature are infrequent, extensive bibliographies are found at the end of each chapter.

The numerous conditions depicted in this book are treated completely yet concisely. The illustrations of the various pathological conditions and the operative procedures are excellent. The chapters on congenital anomalies are especially interesting and this whole field is covered very completely.

This book, while of especial value to the surgeon, would be a valuable adjunct to the library of the obstetrician, pediatrician and general practitioner.

Table of Contents : December 1941

MEDICINE AND THE ANTITRUST ACT	Walton H. Hamilton, New Haven	873
THE PROBLEM OF GASTRIC ULCER	Sara M. Jordan, M.D., Boston	879
X-RAY EXAMINATION OF 8210 SELECTEES AT INDUCTION CENTER, HARTFORD	Paul S. Phelps, M.D. and Helen M. Green, R.N.	882
HOW TO OVERCOME THE SMOKING HABIT	Eugen Kahn, M.D., and Edwin F. Gildea, M.D., New Haven	886
WHAT WE CAN LEARN FROM GASTROSCOPY	James Flexner, M.D., New York	889
LARGE BOWEL CANCER—SYMPOSIUM FROM 16TH CLINICAL CONGRESS	A. W. Oughterson, M.D., New Haven	890
AVERTIN IN TREATMENT OF TETANUS	Bernard S. Brody, M.D., New Haven	896
MORTALITY IN DIABETIC COMA	Alfred Labensky, M.D., New London	898
THE ORIGIN OF THE CONNECTICUT STATE MEDICAL SOCIETY	Creighton Barker, M.D., New Haven	900

EDITORIAL

Doctors and the Law	908	New Superintendent at Mansfield	910
Peptic Ulcer Today	908	Chairman of the Council Honored	911
A Word of Caution	909	Hawaii Medical Journal, Vol. 1, No. 1	911
Who Cares About the Mental Patient	909	Section on General Medicine	911
The Medical Student in the Draft	910		

DEPARTMENTS

FROM THE SECRETARY'S OFFICE	912	PUBLIC AFFAIRS	930
CONNECTICUT HOSPITAL ASSOCIATION	918	INDUSTRIAL HEALTH	932
MEDICAL PREPAREDNESS		THE FORUM	936
The Doctor in the Navy, E. C.		NEWS FROM COUNTY ASSOCIATIONS	937
White, Capt., M. C.	922	OUR NEIGHBORS	943
Station Hospital, U. S. Army Air		NEW BOOKS IN REVIEW	944
Base, Windsor Locks, H. G.			
Woodward, Lt. Col., Air Corps	923		

MISCELLANEOUS

OFFICERS AND COMMITTEE CHAIRMEN		"WE'D RATHER BE BOMBED THAN BORED": A PERSONAL INTERVIEW	927
Connecticut State Medical Society	4	SPECIAL NOTICES	940
Connecticut Hospital Association	4	OBITUARIES	942
ANNUAL SECRETARIES CONFERENCE	915		



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MEDICINE AND THE ANTITRUST ACT

A Discussion of The Government's Suit Against the American Medical Association

WALTON H. HAMILTON, *Southmayd Professor of Law, Yale University School of Law*

MR. CHAIRMAN, Gentlemen of the Medical Profession, and Fellow Students, may I begin with two or three words of explanation? If I appear before you as a layman, in respect to the subject with which we are dealing you appear before me as laymen. We are dealing with a technique very different from medicine. I shall, so far as I can, avoid the words of the law, because they are many, complicated, and interminable. But the difficulty is more than a language difficulty. The process by which the law operates is so different from that which you employ in your everyday work that it is not easy to follow.

Second, I shall, during the course of this discussion wander to and fro, down the ages. I may mention the date 1603, 1623, or 1819, or other dates which seem to savour of the antique. I would hardly expect if I went into one of your offices to find you invoking Galen, Harvey or one of the ancient worthies. If, bothered by symptoms of mine, you should make reference to "21 Jacobus I, Chapter 3," I should probably throw up my hands in horror. But the ways of law are decorous and its authorities venerable. If mine adversary quotes a case of 1621, and I can counter with one from the vinting of 1601, I take that round.

Third, when you resort to law, you invoke a very stubborn diagnosis. You commit yourself to a series of moves which seems interminable; your cause moves from court to court; between the trial and the appeal courts it may even shuttle up and down. As it goes forward—or backward—it is, therefore, essential to keep clearly in mind exactly what the motion is and what stage in the litigation has been reached.

Finally, my concern is with the case in perspective and in its general significance. I have no disposition to pass upon the guilt or innocence of the parties concerned. I shall review particular acts only so far as is necessary to throw into relief the legal questions which are of professional interest.

This is the autumn of the year 1941; yet the events which pass in legal review all occurred during the years 1938 and 1939. If you had a patient whose symptoms were diagnosed in 1938, and in 1941 you were still not free to prescribe, I wonder what the practice of medicine would be like. Yet the case still remains on the court's calendar and months even years may pass before finis can be written to the story.

Late in 1936 a group of government employees, mostly connected with the Home Owners Loan Corporation, decided to form a "medical coöperative" known as the Group Health Association. When that was done, the laymen in charge went to the officers of the District of Columbia Medical Society, disclosed their plans, and called for coöperation. In those early months, four courses of action were debated by the officials of the Medical Society. One was to be strictly neutral and "let the thing go to the devil." The second was "here is an experiment, maybe it won't get anywhere, maybe it will, let's lend a helping hand. It certainly can't make good as outlined, but maybe it can be converted into something that is worthwhile." The third was to checkmate with a group plan under the auspices of the local organization. "Let's set up a scheme of our own which goes in the same direction, preserves the ancient liberties of the profession, and avoids the bad features of Group Health." And the fourth

Address delivered at 158th Semi-Annual Meeting, New Haven County Medical Association.

was, "let's become militant and give the thing the works." There were people in the Medical Society who took all of these various positions. What the general sentiment of the Society was it is impossible to say. The officials were in charge; and, though there was delay and difference of opinion, little by little they drifted toward the fourth position, that of militancy.

The first legal move was a flank attack. The officers of the Medical Society persuaded the District Attorney to ask the court for a declaratory judgment to the effect that "Group Health" was: (a) without a license doing an insurance business; and (2) as a "corporation" was engaged in the illegal practice of medicine. Generally speaking, the courts will not in the abstract make a declaration on what the law is. Usually they wait for "a genuine case in controversy." Then the issue is carried up through the various tribunals to—as the Chief Justice has put it—"the court of ultimate conjecture and final error." A declaratory judgment is gradually coming into the law. It is to litigation what prevention is to the practice of medicine. In a word, the law is declared in advance so that people may suit their actions to it and avoid the bother and expense of needless conflict.

These motions were in due course argued before District Judge Bailey. He admitted "Group Health" to be a corporation, but denied that it was engaged in practicing medicine. It was not the association, but the physicians employed by it, who were practicing medicine. Nor was it concerned with the insurance business. Instead its members had banded together into a "consumers' coöperative" to make a collective purchase of medical services. In medicine a disease by any other name would be as deadly; in law innocence or guilt often wait upon the name by which a thing is called. Insurance—a corporation practicing medicine—unlawful; a consumers' coöperative—legal questions vanish.

Then came certain moves against Group Health by the District of Columbia Medical Society. In respect to these the Government brought its indictment, charging violation of Section 3 of the Sherman Act, popularly known as the Antitrust Act. The counts against the Society, the American Medical Association, and their officials were there in number. The first was interference with physicians—both those who were in the employ of Group Health and those who might in future be so employed—in "the lawful pursuit of their calling."

The second was interference with Group Health in an experiment intended to bring service within the financial means of the common people. The third was the denial to the public at large of whatever benefits might emerge from the provision of a more economical medical service.

All of this was a verbal cloak for a recitation of particular acts alleged by the Government to lie beyond the tolerance of the law. A physician was required to resign his position with Group Health as the price of retaining membership in the Medical Society. Another who persisted in staying with Group Health was expelled from the Society. A threat of "discipline" was made against any member of the Society who permitted himself to be called into consultation by any member of the staff of Group Health. Steps were taken to have the hospitals in the District of Columbia deny "courtesy" privileges to the members of the staff of Group Health. In a word, the Government charged a boycott against Group Health, the physicians in its employ, physicians who took counsel with them, and hospitals which extended their facilities to them.

Such, in the broadest terms, are the counts. To any indictment, the defendants can enter one or another of two pleas. They may admit or deny their guilt; if they deny, the case goes to trial, and the burden of proof is upon the party who alleges illegal conduct. Or they may insist that the statute under which they are haled into court does not prohibit the specific conduct with which they are charged. In technical terms, they may answer or they may demur; or, in popular language, their choice is to say it-ain't-so or to ask what-of-it.

When, at a preliminary hearing, the defendants appeared before Judge Proctor, it was to ask what-of-it. Their demurrer took three lines. First, Group Health was illegal; for a corporation, which had no sanction to do so, was illegally practicing medicine and selling insurance; and surely there was no wrong in interfering with an illegal concern. Second, the indictment was faulty. It was so colorful and so detailed as to prejudice the jury against the individual whom *it sought to convict*.¹

Third—the one which was pressed the hardest—physicians are not subject to the prohibitions of the Sherman Act. For the law forbids restraint of trade;

1. At the close of the trial, the attorneys for the defendant insisted that the jury should not take a copy of the indictment with them when they retired to make up their verdict.

and, since medicine is not a trade, practitioners of medicine can not possibly engage in restraint of trade.² Judge Proctor sustained the demurrer and the Government took an appeal to the Circuit Court of Appeals.³

As the appeal was taken, it was the law and not the defendants, who went on trial. At this stage there was no question of guilt or innocence; the issue was the abstract one of whether physicians could be brought into court for violation of the antitrust acts. No more, no less, was under consideration than what the law is, and whether it applied to the kind of situation recited in the indictment.

The government's contention was that whether medicine is a trade or a profession had nothing to do with the case.⁴ It was perfectly willing to concede that medicine is a profession, a noble profession, a learned profession. But it insisted that no question concerning the practice of medicine by a physician was at issue. Instead the concern was wholly with the economic arrangements under which medicine is made available to the people. The doctor can meet his patient under any one of an almost infinite number of arrangements. Therefore, the heart of the case was the economics of medicine, not medicine as a profession.

The appeal presented a question of strategy; the issue might turn upon the line of attack. It was possible to exalt the common health, insist that current service was inadequate, play up Group Health as a great forward movement.⁵ Or it was possible

to ground the argument in the ancient precedents of the common law. In the end the more legalistic attitude prevailed; the dust was blown off of all the old books; rules, principles, citations were sought which, carrying across decades and even centuries, could do doughty duty in a modern bout at law.

So it was contended that there was here no issue over medicine and "trade." Rather the question was whether certain individuals, who happened in the instance to be physicians, had been guilty of the offense known at law as "restraint of trade." If you will write the term not as restraint of trade, but as restraint-of-trade, you will have a key to the line of argument. You cannot look up the word "restraint" and the word "trade" in the dictionary, and by putting them together find what the term means. You might just as well, by looking up the separate words try to determine what "last clear chance" or "due process of law" means. In other words, "restraint of trade" is a term of art. As such it has little by little accumulated its meaning over a period of years. Therefore, the meaning of the term is to be discovered in the history of the law.

The question is the meaning of the term as set down in the Sherman Act under which the indictment was brought. This statute which was passed by the Fifty-first Congress and became a law on the 2d of July, 1891, has had an extremely interesting history. The original bill, introduced by Senator Sherman, was a thrust at the trusts, just then becoming big and powerful. It was aimed at persons who sought to lessen competition or to enhance the price of goods to the consumer. As it was debated it was amended, and as amendment after amendment was added, it lost alike its objective and its integrity. Eventually, as a thing of shreds and patches, it was referred to the Judiciary Committee. Depairing of straightening out the tortuous lines, the Committee scrapped the bill and with Senator Hoar as draftsman, rewrote the statute. It defined no new offense. It simply put a ban upon all conduct known to the common law as "restraint of trade."

It is always a task to discover the range and meaning of a statute whose lines are as lean as the Sherman Act. In this instance the history of the measure points the way. The bill which was debated was

2. This did not stop the same attorneys from analogizing the medical society to an association of working men, and claiming for the A.M.A. all the immunities which the courts have accorded to the trade union.

3. Had the demurrer been overruled the case would at once have gone to trial. At this point, the plaintiff has an appeal, but not the defendant. The reason for the difference is common sense. If the case goes against the defendants, they can argue their demurrer along with their conviction; so no rights are lost. But, unless the government can appeal at this point, its case can never be brought to trial.

4. Just to get the record straight, a personal confession is in order here. At this point I entered the case in a minor role and wrote about half of the government's brief on the appeal. Again, to keep the record straight, I took no subsequent part in the proceedings.

5. It is of note in passing that the appeal was to be argued before a bench of three chosen from a court of six judges. Since these differed in attitude, experience, legal specialty, the world that moves beneath the hat, it might make a difference just who was to sit. Since this was not to be known in

advance, lawyers on both sides were in something of a quandary as to just what to plead. The government, for instance, might have plead the "liberal cause" of seeking to promote the common health. Instead, it took a conservative stand and bottomed its case on the common law.

never passed; the bill which was passed was little debated. The quest for content runs away from the Congressional Record to the annals of the courts. There it is discovered that the reports abound in cases of restraint of trade. And, strange as it may seem to the laymen, there are more of these which concern medicine than any other calling. In fact an appendix to the Government's brief lists more than one hundred cases in which courts had applied to the medical profession the doctrine of restraint of trade.

It comes up in this particular way. A doctor sells his practice to another physician. He agrees for a certain period of time and within a certain territory not again to engage in practice. After a time the itch of the calling comes upon him, and he can remain idle no longer. Sooner or later, the old shingle is hung out again, whereupon the doctor to whom he has sold his practice brings suit against him for breach of contract. When it goes into the court, the doctor who rues his bargain pleads, "Yes, I have broken my contract, but the contract is illegal." For what reason is it illegal? "It is illegal because it is in restraint of trade and therefore void as against public policy." Sometimes the court finds for the plaintiff and awards damages; sometimes it finds for the defendant and dismisses the suit. But, in every instance, the norm of reference is the prohibition against restraint. In fact, so far as the cases go, the doctrine of restraint of trade is better established in respect to medicine than any other occupation. The criminal penalty in the Sherman Act is new but the offence is old. The sole novelty is in making a misdemeanor out of what had long been recognized as a common law wrong.

The Governments' argument was to the effect that the Sherman Act is general; that restraint of trade is an offence of which any person, corporate or natural, may be guilty; that its domain is universal. True, there can be an exception; but the exception must be decreed by the legislature which has passed the act. And every exception must be explicit, for adequate cause, by proper grant. Exceptions to the general law cannot be based upon inference or implication.

To the Sherman Act a number of exceptions have been written. They fall roughly into two general classes. The first are in respect to certain services where the consumer cannot best be served by competition. The public utility companies are the best example. But in such cases the state itself sets up a

regulatory commission as substitute for competition. The second presents an attempt of the state to favor the weaker party to the bargaining process. The best example is in connection with labor. Statutes of the United States encourage working men to bargain with their employers as a unit. The theory is that such unity of action is necessary to encourage "that equality of bargaining power in which freedom of contract begins." A like exception has been written in favor of farmers' coöperatives in the Capper-Volstead and the Agricultural Marketing Acts. But lest indulgence be pushed too far, those statutes provide that if the Secretary of Agriculture has reason to believe that the exception in any way tends towards monopoly, he shall take appropriate steps to hold it within lawful bounds. In all such instances the attempt is to lift the weaker party to an equality in bargaining power; but the moment a favored group rises above that plane, it transgresses the law.

So the question occurs, is there any exception on which the officials of the medical association can rely? It must, mind you, be explicit and by special legislative grant. Take first the American Medical Association a corporation of the State of Illinois. It was chartered under the corporation act of a particular state, and it was not given a special charter. The instrument under which it operates is simply one of hundreds issued under a general enabling act. It contains no saving clause in favor of the medical profession. Nor, if there were, would it be of any value; for a state of the union can grant no immunity to a Federal act.

The Medical Society of the District of Columbia is, however, upon somewhat firmer footing. Its character came by way of a special act of Congress, the very body which passed the Sherman law. If, therefore, a saving clause can be discovered within the four corners of the charter, it is possible to plead an immunity. The original grant dates from 1819; as the preamble declares the grant was made for the purpose of "promoting and disseminating medical and surgical knowledge and for no other purpose whatsoever." A section of the charter expressly provides that "nothing herein contained shall authorize the said corporation in anywise to regulate the practice of medical or chirurgical attendance upon such persons as may need those services nor to establish or fix a tariff of charges." The grant gives to the Medical Society the right to license physicians. That power was later taken away by an Act of Congress.

In 1924 Congress amended the charter of the Medical Society. Again the purpose was limited to promoting and disseminating medical knowledge; again was added the words "and for no other purpose." No prohibition covering the regulation of fees was deemed necessary, presumably because Section 3 of the Sherman Act covered the matter.⁶ The discussion on the floor indicates that Congress desired to limit the activities of the Society to its avowed objects. Nowhere is it written that the Society may concern itself with the economic aspects of medicine.

A collateral chapter of history moves to the same result. In the sixteenth century, when the common law was in the making, the English government operated to a large extent through corporations of its own creation. All sorts of public functions were delegated to the half-private, half-public body known as "the honorable company." One of those charters—a most interesting document—was issued to the College of Physicians of the City of London. It gives to that body the right to license all physicians. It gives to it the right of "search and seizure" in respect to all medicines and medicinal products which come to market. The College had its own court, policed a public domain, imposed its own sentences, even sent transgressors to jail. There was, in a word, an autonomous control of the medical profession by the College of Physicians. As the use of private agencies to do public work fell away, the "liberties" of the College were later restricted. A copy of this old document seems to have been before Congress in 1819; for a number of paragraphs in the charter of the Medical Society of the District of Columbia are identical in language with its provisions. It is, therefore, significant, that all powers of police, and all authority in respect to the economics of medicine are omitted from the District Society's Charter.

In days of old the law undoubtedly recognized immunities in respect to the learned professions. At the close of the Middle Ages the affairs of the church were rather generally beyond the reach of the secular law. But in recent centuries the legal trend has been towards a general law which treats all alike. As against class or calling no principle is

today better established than "equality before the law." So the Government concluded its argument with the statement that the law did not spend centuries, first to abate and then to abolish benefit of clergy, to confer its immunity upon the more secular calling of physician.

The appeal of the Government was successful. The Circuit Court reversed Judge Proctor and overruled the demurrer. A petition by the defendants to the United States Supreme Court was denied. So, after much-to-do over the law, the suit eventually went to trial before Judge Proctor. In this ordeal the Government put forward two distinct lines of testimony. The first was a series of documents gathered from the files of the accused. In accord with its usual procedure, the Government secured from the court and served upon the District Society a subpoena duces tecum—"you come into court and bring with you." You might almost add to that "Cum filing case." In other words, "Bring all of your records." It was as if the Government had said, "These charges must be tried by the facts; we haven't the facts but you have; bring them into court."

If I may be permitted to say so, the officials of the Society had behaved like amateurs, not like hardened criminals, at the game of restraint. They put things in writing which no baron of big business would ever allow to escape the secrecy of private conversation. An example or two will make the matter clear. A resolution begins, "Whereas the Medical Society of the District of Columbia has an apparent means of hindering the successful operation of Group Health Association." A statement by an official of the Society urges indirect attack, insisting that whatever plan is used, it must be "camouflaged to the n-th degree." It is easy to multiply instances of such indiscreet statements.

Second, the Government introduced evidence of overt acts on the part of the defendants. As is the habit of lawyers, the attorneys for the government tried to make their exhibits as dramatic as possible. They presented instances of individuals taken to hospitals in the dead of night in demand of immediate surgical attention. As usual, it was the zero hour, the cold winds blew; snow lay upon the ground. In such circumstances the patient was turned away, the Group Health surgeon was denied the right to operate, and in one instance a junior member of the regular staff was alleged to have run by all the red lights and to have performed an un-

6. In the original debate, leading to the Sherman Act, Senator Morgan had asked if medicine were not included within the proposed measure. Senator Sherman did not know. The Government in the instant case plead "the silence of Congress" against any exception.

necessary operation. There was material for an exciting show and the lawyers for the government did not stint its use.

Attorneys for the two sides "summed up," each giving an impartial history of the case from his own point of view. Each side prepared proposed instructions to the jury and passed them along to the judge. The judge accepted the majority of the instructions presented by the defense, but turned several down. In these instances the defence took exception as the basis for an appeal. As with the defence, so the instructions prepared by the plaintiff were accepted or rejected at the pleasure of the court. In addition the judge delivered a number of instructions of his own and sent the case to the jury. The jury deliberated a few hours and you know the result. The list was called: "American Medical Association"—"Guilty." "Medical Society of the District of Columbia"—"Guilty." Defendants A, B, C, D, . . . N, "Not Guilty." The American Medical Association and the District Society had violated the Sherman Act, but no official or member connected with either had engaged in restraint of trade. The two corporations had acted, but without the intervention of any human agency whatsoever. The verdict has led to the judgment being known around the Department of Justice as the Case of the Immaculate Conception.

Yet such a result is not surprising. The judge instructed the jury to weigh the whole of this evidence in respect to each one of the defendants. Note the intellectual problem with which each of the good men was confronted. Let us list every act that is done along the left of a page; let us list the name of the several defendants across the top of the page. Then down the columns a checkmark is made every time a specific act is proved against a particular defendant. You can see the intricate problem in imputation which is presented. And since twelve true men are sitting and the judgment must be unanimous, the checkmarks must go down in the same places.

The Association and the Society has taken an appeal to the Circuit Court. If they lose there, they will probably appeal to the United States Supreme Court. As to success, these can at this time be only an opinion; and in speculation upon what courts will do, doctors are every bit as good as lawyers. The best chance for the defense would seem to be to set their argument in reverse, insist that physicians are tradesmen, and claim whatever immunities have

been accorded to trade unions. The Norris-La-Guardia Act, with its cloak of protection for "collective activities" is a possible refuge, and the recent decision in *U. S. v. Hutchinson* might prove a sanctuary if physicians can prove to the court that they belong under an umbrella erected for the carpenters' union. But, since benefit of clergy has gone, it is hard to see where else they can find an immunity for the profession.⁷ After all these years the case is still unfinished business—and we shall see what we shall see.

In conclusion, may I append two or three personal comments. First, nobody is called upon to like Group Health. Physicians are free to talk about it, write about it, damn it just as much as they please. But when they combine to dictate to hospitals that members shall not be put upon their staffs whose sole offence is active participation in a new form of medical organization, that is going a little bit too far. Persuasion is one thing, a concerted boycott something else again. Nor is it quite persuasion to ask for immunity for doctors in respect to conduct that would not be tolerated on the part of big business men.

Second, it seems to me almost mediaeval to get a question of this kind settled by resort to the courts. Surely some reference ought to be found a little more modern than a norm of restraint of trade whose meaning was fixed in the law at least as early as 1621. Nor does an interminable legal process, in which a case shuttled around the courts for years, appear an ideal way of deciding how far an organized group of physicians may go in giving effect to their views.

Third, the distinctive character of the physician's service should have greater recognition than has been accorded it here. It is not like things which are bought and sold; it is not even like other services. Any one of you can draw up a catalogue of differences; a couple of items is enough to drive home the point. One is that the practice of medicine is essentially a public—even if not a governmental—office. In your dealings with us a doctor is not a stranger that we meet and bargain with at arm's length. We as laymen have little capacity to judge the quality of your work. In the very nature of things you hold an office in trust; you must protect

7. One, at least in a footnote, may be permitted to remark that it hardly seems consistent to argue 1) that medicine is not a trade, and 2) that a medical society is entitled to the legal immunity of a trade union.

our interests as well as your own. Two, medical services can not be marketed as are ordinary goods. There is no unit of weight, length, time, by which a doctor's work for us can be measured. An hour with an expert diagnostician is worth a hundred hours with a routine practitioner. Medicine is an art; the mark of art is quality; quality cannot be measured. In a word, in appraising medicine, the techniques of the market are out.

Finally, the question of the economic arrangements under which medicine is to be practiced is insistent. In the instant case the Government took the position that as between "private practice" and group health it played no favorites; that its demand was only for a fair field and no favors. And to the same effect the judge charged the jury. But neither physicians nor the great laity they serve can afford so Olympian an attitude. The private practice of old has, whether you like it or not, been modified beyond recognition. New economic arrangements have appeared under which people have access to the facilities of health. Of change there is no better

evidence than that Group Health could not carry on without access to hospitals and to specialists with whom they could consult. Change has come, yet it has been little directed. The old is departing; yet there is no new order to replace it.

The plain truth is that the economic organization in medicine is backward compared to its technology. Private practice is no longer adequate to the needs of the nation; and I agree with you that medicine lends itself more clumsily than almost any other service to a regimented system under state control. Somewhere in between the answer lies; as the economics of medicine is brought up to date, invention must get in its work. The professional independence of the physician must be retained; yet his work must be set within arrangements which bring the requisites of wellbeing to the great mass of the American people at prices they can afford to pay. If I may restore to currency an old term, the task is, amid the modern condition of life, to devise ways and means by which the doctor becomes again the great personal instrument of "the common health."

THE PROBLEM OF GASTRIC ULCER

SARA M. JORDAN, M.D., *Boston*

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THE PROBLEMS of most diseases are usually solved by accumulated experience, but in the case of peptic ulcer, at least some of us who deal intensively with this disease are ready to confess that increasing experience is productive not of dogmatic deductions but only of the conviction that all conclusions, even those most carefully based on statistics, are constantly subject to change and even reversal. This will be true, probably, as long as fundamental knowledge of etiology is still deficient. However, there are a few basic facts, dealing with etiology, with diagnosis, and with treatment of peptic

ulcer, whether gastric, duodenal, or jejunal, which have been substantiated by experience. If we consider, first, etiology, we must continue to acknowledge the dominant role of spasm and hydrochloric acid, secondary, of course, to any factor which produces spasm—whether psychic, such as by emotional crisis; nervous, as from an excessive or protracted period of mental or physical strain and fatigue; infectious, as from a respiratory infection; chemical, as from smoking or excessive alcohol; or mechanical, as from food difficult of digestion. Any one of these factors alone or in combination with another is notoriously responsible for the initial or the recurrent episode of peptic ulcer in the susceptible individual. The susceptibility factor is still the X, the unknown quantity.

In the diagnosis of the peptic ulcer, whether it is

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gastric, duodenal, or jejunal, it is imperative to make certain decisions. First, is there an actual ulcer present or are the symptoms due to another organic disease, or to a functional condition, especially the type of functional condition which is a forerunner of actual ulcer? A failure to diagnose an actual ulcer has a penalty so obvious that discussion is unnecessary, but a diagnosis of ulcer where it does not exist involves a regimen with restrictions which are quite unjustified unless the actual lesion is present. Furthermore, a diagnosis of a functional condition which is a forerunner of ulcer, namely, habitual pylorospasm and hyperchlorhydria, is, in our experience, a valuable finding and one not to be passed over too lightly, because it may be an aid in the prevention of ulcer, which in these days is a legitimate and laudable aim of gastroenterology. Secondly, if an ulcer is present, is it in an active or a healed state? Such signs of irritability, as hyperactive peristalsis, marked hyperchlorhydria, the actual identification of an ulcer crater, tenderness over the lesion, together with typical symptoms, are indications that the lesion is present and active and requires intensive treatment for immediate and complete healing; whereas an x-ray deformity due only to the puckering of the ulcer scar and without signs of irritability, even in the presence of symptoms, indicates a healed lesion, which requires a less rigid regimen. The symptoms, in such cases, are usually due to the habitual pylorospasm which occurs not only as a forerunner of the initial ulcer, but also in the intervals between, and when uncontrolled, as a forerunner of actual recrudescences.

In the treatment of the peptic ulcer, all three types, gastric, duodenal, or jejunal, are amenable to the same regimen, whether medical or surgical. The basic principles of medical treatment are rest and neutralization, each of which affects favorably both the causative agents, spasm and hyperchlorhydria. Rest means as complete and general physical and mental rest as are attainable by hospitalization, and as complete local digestive rest as is procured by a most protective diet and the elimination of both chemical and mechanical irritants. Neutralization means the use of food and a chemical agent to combine or neutralize the free hydrochloric acid at all times of day and night. By these measures, a temporary quietus is put upon gastric activity, and a temporary neutral media obtained for the promotion of healing. If rest and neutralization can be applied intensively enough, and before penetration of the ulcer into neighboring structures, the peptic ulcer

in any location will, in my opinion, heal. The intractable ulcer is, in our experience, only intractable because for some reason rest and neutralization cannot be accurately applied, or because penetration into an adjacent structure, particularly the pancreas, makes healing impossible.

Surgical treatment purposes to remove the actual lesion and to prevent a recurrence. To be effective, it, too, must be carried out so that neither spasm nor hyperchlorhydria shall cause a recurrence. The usual failure of gastro-enterostomy to attain this objective is now well known. Resection, in our experience up to this point, is successful in this respect in the great majority of cases, and the risk of radical surgery and the loss of the major part of the stomach are a high but sometimes necessary and justified price to pay for ulcer intractability.

The special problems of the gastric ulcer, which is the specific title of this paper, have to do with particular difficulties in diagnosis and with the choice of medical or surgical treatment. These difficulties are of major importance because in the gastric ulcer, as contrasted with the duodenal and jejunal, we have the added danger of confusion of the benign and the malignant or potentially malignant lesions.

The location of the gastric ulcer is of great importance. If it is located on the free anterior surface or the anterior side of the lesser curvature, there is no extension of the burrowing process into an adjacent structure. If the ulcer is deep enough to perforate the wall of the stomach, the perforation is dramatic and is cared for at once by surgery. Furthermore, such lesions can be clearly visualized and the progress of their healing easily followed. On the other hand, any ulcer of the posterior wall, whether it is in the media or prepyloric area, has two inherent disadvantages: (1) it is difficult to detect the lesion and diagnose it originally, and equally difficult to follow the course of healing, and to be certain that no malignancy exists; (2) the ulcer may and very often does penetrate through the muscularis and serosa into pancreatic tissue and embed itself in the pancreas. Increased severity of the pain usually indicates that this has occurred, and such ulcers heal with much more difficulty than when the ulceration involves only a part of the stomach wall.

The first difficulty, that of visualization, is due chiefly to two facts—(1) that the posterior wall of the media is obscured by the filling of the stomach with barium and the ulcer crater never visualized and (2) that the lesion of the prepyloric area is

obscured by spasm, and especially if it is a posterior wall lesion, is difficult to find.

The diagnostic manoeuvre of using a small amount of thick barium or a special preparation to outline the rugae of the stomach before the stomach is filled, and of flattening out with pressure the posterior wall and filling any existing crater, is of great value. When this is successfully used, it gives an accurate first estimate of the size of the ulcer, and subsequent observations of size of the crater indicate the rate of progress of healing. Sometimes, however, the area of stomach involved lies too high for pressure palpation, and then the crater is filled only casually when the patient lies in the supine position. This casual type of filling is neither a consistent finding nor is it a reliable guide of the size of the ulcer, or the progress of healing.

The prepyloric lesions are so often disguised by spasm, and pylorospasm is such a frequent finding in both gastric and duodenal ulcer, that both the small ulcer and the early carcinoma located prepylorically, may often escape detection. When the usual antispasm drugs are ineffective, as they often are at the beginning of treatment, a few days of intensive medical management and re-examination sometimes reveal the lesion.

These lesions of the posterior wall and prepyloric area, like those of the lesser curvature, may be either benign or malignant. The same criteria in doubtful cases may be used to determine their nature; viz., a period of medical management with the decision for malignancy, present or potential, based on three criteria—(1) complete disappearance of occult blood from the stools; (2) complete disappearance of symptoms; (3) complete disappearance of the x-ray defect.

The first two criteria may be easily checked, but because of the difficulties of visualizing a defect in the areas just mentioned, it is often not easy to be certain that there is a complete disappearance of the x-ray evidence of ulcer. The gastroscope often supplements the x-ray findings satisfactorily, but if it, too, fails to visualize the lesion, there is always the danger that an incompletely healed ulcer or a small ulcerating malignancy is still present.

These two difficulties of posterior wall and prepyloric lesions: (1) unsatisfactory healing when the ulcer has penetrated into the pancreas; and (2) unsatisfactory visualization and difficulty in following the progress of healing, make it possible for the small originally malignant lesion in this location to go undetected, and for malignancy to occur later

and undetected in the chronically unhealed ulcer.

Those distressing cases of cancer of the stomach which have been diagnosed both by x-ray and occasionally even by surgical exploration as gastric ulcer, and which appear to have a healed ulcer for a certain period of time only to develop a later malignancy, belong, in my opinion, to this group in whom the ulcer either remains always to some degree unhealed or recurs. Both the failure to heal completely and the recurrence are evidence of chronic irritation in a terrain notoriously susceptible to malignancy.

Repeated massive hemorrhages from gastric ulcer are much less frequent than from duodenal ulcers, but when they occur, they are also evidence of failure to heal, often again due to a process of burrowing into the pancreas, with the exposure and erosion of a vessel. Recurrent hemorrhage, therefore, indicating failure to heal permanently, should per se be a reasonable indication for resection in the gastric ulcer, however one may feel about hemorrhage from a duodenal ulcer.

Localized sub acute perforations are likewise usually evidence of burrowing into adjacent structures. Since this makes ulcer healing difficult, surgery should be considered unless there is satisfactory evidence of rapid and complete healing.

The most important criterion of satisfactory healing has been the complete disappearance of the x-ray defect. In our experience, the greatest care should be used to be certain (1) that there is after obvious clinical healing, not even the slightest vestige of the ulcer crater; and (2) that the gastric wall in the area of the ulcer is entirely flexible. Both these conditions must be fulfilled to constitute complete disappearance of the x-ray defect. The time limit within which this complete disappearance should occur may vary somewhat, but unless it has occurred within three to four weeks after the beginning of treatment, there is probably a chronically unhealed area in the ulcer which we believe may well be the nucleus of a malignant lesion.

Recurrence of gastric ulcer has until recently been regarded by us with not too great anxiety. If the recurrent ulcer fulfilled the same criteria of complete healing, we felt assured that it was as benign as the original ulcer. Recent experience with recurrent gastric ulcer have caused us to change our opinion in this matter, and we would now add to the other three criteria of benignity, a fourth—that the gastric ulcer does not recur. And, in my opinion, all recurrent gastric ulcers should be resected because like the unhealed ulcer, they represent chronic irri-

tation in this organ which is so susceptible to malignancy.

In summary, the following points may be deduced from our experience:

(1) Ulcers of the posterior wall of the stomach, whether of the media or prepyloric area, are most difficult to find and to follow, and at the same time, their healing may be interfered with because of penetration into the pancreas.

(2) In the gastric ulcer, sub-acute perforation, particularly with penetration into the pancreas, and repeated hemorrhage, indicate, respectively, difficult and only temporary healing, and should therefore be regarded as conducive to chronic irritation in the stomach where malignancy occurs so often.

(3) Recurrence of gastric ulcer should be regarded as a fourth criterion for possible malignancy in doubtful cases, the other three criteria being failure of disappearance of occult blood, symptoms, and x-ray defect.

(4) The strictest standards for disappearance of the x-ray defect should be established, including complete disappearance of the crater and complete restoration of flexibility in the stomach wall.

(5) Finally, it is our opinion that certain cases of gastric carcinoma supervene upon gastric ulcer which has incompletely healed or recurred, and that for this reason the greatest care should be used to insure complete healing of the gastric ulcer and the most exacting technique employed to detect incomplete healing.

X-RAY EXAMINATION OF 8210 SELECTEES AT THE INDUCTION CENTER, HARTFORD

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ON SEPTEMBER 16, 1940, the President of the United States signed the Selective Service Act. The first registration of selectees began October 16, 1940. The date of induction for the first of these selectees in the State of Connecticut was set for November 15, 1940.

Those interested in tuberculosis control began to investigate the various ways and means available for x-raying the large groups of young men, 21 to 36 years of age, who were to be selected for a year's training in the United States Army.

The experience of the last World War had convinced nearly everyone that an x-ray examination of the chests of men entering the Army was essential. The United States Government has spent a little less than one billion dollars in compensation for disability of tuberculous soldiers and approximately

\$140,000,000 for their hospitalization.

In November, 1940, when the first group of men from Connecticut were to be inducted into the selective service, the Government was not prepared to take chest x-rays although the necessary apparatus was on order.

The Tuberculosis Commission was particularly anxious that this survey be carried out because it was known that the ordinary physical examination contemplated by the local boards and the Federal group at the Induction Center would probably miss 80 to 90 per cent of the cases of tuberculosis, no matter how carefully the examination was done.

If these unknown cases of tuberculosis were allowed to enter the army, many would undoubtedly break down after a relatively short stay in training and expose others from this state who lived in close contact with them in the army quarters.

Many of the men exposed to such open cases while in the army would subsequently develop tuberculosis either while in the army or shortly after they had finished their year's training, and thereby expose their families, friends and fellow workers at home.

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On the other hand, if all cases of adult tuberculosis could be found, many minimal quiescent or minimal arrested cases could be returned to their ordinary occupations under supervision and continue to live in good health.

The minimal active cases could be given immediate sanatorium care, and, within a reasonably short time and at a minimum cost, their disease could be arrested. Such individuals could be safely allowed to return to society as useful citizens.

In the advanced cases, adequate treatment could be given before symptoms had developed, their resistance exhausted, and while there was a reasonable chance of "cure." The advanced inactive and quiescent cases, if rejected and made aware of their disease, could under proper supervision be expected to maintain reasonably good health and continue to be self-supporting citizens.

Such a program, if properly carried out, would serve two very important functions, the "cure" or supervision of those with disease, and the prevention of its spread.

It was realized, also, that a thorough investigation of all contacts of these cases should be made to determine from whom they had contracted their disease, and to whom they may have given it in their own local communities.

The exact savings in dollars and cents are difficult to estimate, but, if the Federal Government calculates that a case of tuberculosis developing in the army costs them \$10,000, this may give some idea of the saving in money that would result from such a program of prevention, to say nothing of the saving in lives.

The Tuberculosis Commission realized that it was important not only to the United States Army but to the State, the local community and the individual, that men having tuberculosis be found and rejected from military training. Therefore, it instructed its case-finding division to investigate possible ways of x-raying this group.

The first step made by the Director of the Case Finding Division of the Tuberculosis Commission was to consult Colonel William B. Smith, State Medical Director of Selective Service, concerning the possibility of getting the selectees x-rayed at the time of the first examinations by their local Medical Boards. After discussing this possibility with Colonel Averill, the superintendents of various hospitals, and many others, this method was clearly shown to be impractical. There were difficulties associated with lack of x-ray facilities, the cost in any event would

have been prohibitive, and the problem of transporting the thousands of selectees to and from x-ray departments seemed impossible. As desirable as this plan had at first appeared, it was abandoned. An approach was made, therefore, to Lieutenant-Colonel Putnam in charge of the United States Recruiting Station in Hartford, and also Commanding Officer at the Induction Center, to determine whether they would permit the Tuberculosis Commission to set up x-ray equipment at the Induction Center (then at the Y. M. C. A.) and x-ray these men as they came up for their final examinations. Permission was granted and the apparatus was set up in the locker room of the Y. M. C. A. on Pearl Street.

The men were to arrive at the Induction Center between 7:30 A. M. and 12 o'clock noon from various parts of the state in groups numbering from 50 to 300. They were to be examined and inducted into the Army by 4 P. M., and were to be on the train leaving Hartford shortly after 5 P. M.

It was no small order to work out a method of x-raying these men so that the line would not be held up, to say nothing of getting the films developed and read in time to prevent the induction of a tuberculous selectee. However, the problem was worked out satisfactorily in the following manner.

A small portable x-ray was set up with a portable Cassette Holder. Mr. Jean Kieffer of Uncas-On-Thames Sanatorium designed a portable darkroom which was placed within a few feet of the x-ray equipment. Four men manned this equipment and they became so proficient that x-rays could be taken at the rate of approximately two per minute. Celluloid films, 14" x 17", were used and, when twenty to thirty of these had been exposed, they were placed in light-lock boxes and were taken by car to Cedarcrest Sanatorium where they were developed. These films have proven to be quite satisfactory.

Developing such large numbers of films in a short period of time required considerable ingenuity, and a wet film holder had to be designed and made by the staff at Cedarcrest Sanatorium. The films, while still wet, were read by a physician stationed at Cedarcrest. Those men found to have x-ray evidence of lung pathology were x-rayed again to prevent error. By 3 P. M. all x-rays had been read and the cases found and verified were reported to the Induction Center by telephone. The greatest delay in this procedure was occasioned by the necessity of transporting the exposed films five miles to Cedarcrest Sanatorium for developing.

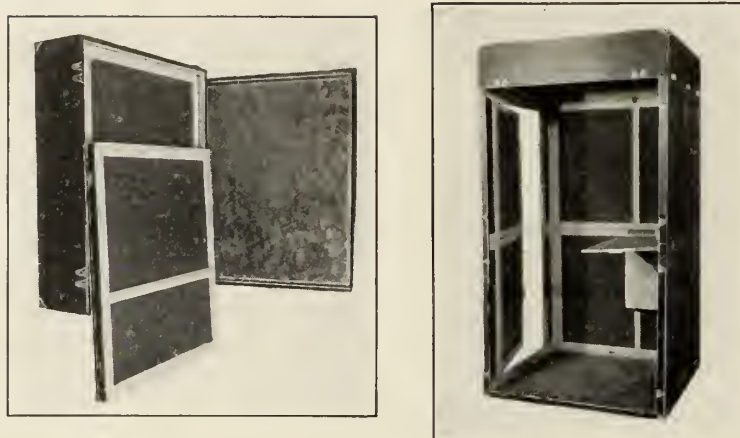


FIGURE 1

Portable Darkroom containing loading bench, light lock film boxes (one on either side of loading bench), and darkroom light, weight 130 lbs., can be placed in trunk of a car. Designed by Jean Kieffer, Uncas-on-Thames Sanatorium.

The officials at the Induction Center have been at all times most coöperative, supplying everything within their power necessary to carry out this program. In November 1940 the Army was unable to supply any personnel, equipment, x-rays, or solutions. However, as this x-ray program has progressed, the Army now employs three men to assist the technician at the Induction Center, and a truck and driver to transport films to Cedarcrest; it reimburses the State for the salaries of the two technicians supplied by the Tuberculosis Commission during the induction periods, and supplies all films and solutions necessary. Only the physician interpreting the films receives no compensation from the Army. The x-ray apparatus being used at present belongs to the State Tuberculosis Commission; however, it is expected that Army equipment will replace that of the Tuberculosis Commission within the next month.

As far as is known to date, Connecticut is the only state (at least in New England) that has been able to x-ray, develop, and read films in time to prevent tuberculous selectees from being inducted.

Briefly, out of 8210 x-rays taken, 58 definite cases of tuberculosis were found. The case find was 0.7%. The x-ray appearance of 34 of these selectees indicated to the physicians interpreting them that they should be admitted to a sanatorium, either for treatment or for a period of observation; of the 34, twenty-one have been admitted to date. It has been found generally that approximately 50% of the cases

discovered among selectees should receive sanatorium care. Of the cases found, 43.1% were minimal, 37.9% moderately advanced, and 19.0% were far advanced.

This survey of the selectees illustrates one very interesting point, viz., that not one of the 58 cases found had physical findings which were discovered by the usual examination with a stethoscope. In every case these men were examined twice, first by the local medical board, and on a second occasion by the medical examiners at the Induction Center.

When a selectee was rejected at the Center because of lung pathology, he was given instructions to immediately contact his family physician.

The local Health Officer in the town from which the patient came was notified that a selectee from his community was a suspicious case of tuberculosis, and that the patient had been referred to his family physician. The family physician was given the interpretation of the x-ray taken at the Induction Center, and it was indicated in the letter that, should it be impossible for financial reasons to secure an adequate re-examination, arrangements could be made at one of the State Sanatoria. Finally, the Public Health Nurse was notified to contact the family physician to determine whether her services were needed to assist in arranging for the examination of the case and the contacts.

Those cases of tuberculosis on whom we received no report of re-examination were visited by the Supervising Public Health Nurse on the staff of the

FIGURE 2

Photographic copies of x-rays taken of tuberculous selectees, demonstrating the extent of some of the lesions found by x-ray.



1. Far advanced bilateral pulmonary tuberculosis.
2. Large cavities both apices.
3. Sputum—Positive.
4. Refused sanatorium care.
5. No contacts examined, although presumptive source of infection known.

1. Far advanced bilateral pulmonary tuberculosis.
2. Multiple small cavities both apices.
3. Sputum—Positive.
4. Admitted to Sanatorium 5-31-41.
5. Contacts all examined, presumptive source of infection known.

1. Far advanced bilateral pulmonary tuberculosis.
2. Multiple large cavities throughout on the right.
3. Sputum—Positive.
4. Admitted to Sanatorium.
5. All contacts examined; Presumptive source of infection known.

Case Finding Division of the State Tuberculosis Commission.

Unbelievable as it may seem, many of the selectees after being told at the Induction Center that they had tuberculosis and were advised to see their family physician, simply neglected to consult any physician. In several other instances the only recheck of the rejected selectees was a single physical examination without x-rays or other laboratory assistance, and on the basis of this the patient was advised that if he had tuberculosis it was inactive.

To confirm the diagnosis made at the Induction Center the patient should be re-x-rayed (stereoscopic). To determine whether the lesion is active requires a very careful history, physical examination, repeated sputum examinations, sedimentation rates, and, perhaps, repeated x-rays over several weeks or months. Where there is any doubt as to the activity of the lesions found, the patient should be advised to go to a sanatorium for a period of observation.

To date, two additional cases have been found among the contacts although at this time only relatively few of the contacts have been examined.

The results of this survey indicate that:

1. A little less than 1% of the apparently

healthy, young adults found physically fit at two physical examinations and recommended for induction into the United States Army, have adult pulmonary tuberculosis—about 50% of which need sanatorium care.

2. The usual physical examination is of little value in ruling out the presence of pulmonary tuberculosis.

3. An x-ray of the chest is essential if all cases of tuberculosis are to be prevented from induction into the United States Army.

4. None of the group found in this survey had symptoms that would indicate the presence of pulmonary tuberculosis.

5. Some patients are refusing sanatorium care because they do not have symptoms, or do not realize the serious results of delay in treatment.

6. Some physicians are reluctant to advise sanatorium care in the symptom-free cases of tuberculosis.

This survey serves to illustrate, among other things, that there are large numbers of our adult population, perhaps as high as 2%, who have pulmonary tuberculosis and are unaware of it. It also demonstrates quite clearly that mass x-ray surveys must be carried out if these symptom-free cases of

tuberculosis are to be found early enough to effect a "cure" and prevent further unnecessary spread of the disease. It illustrates, too, that the x-ray is not being used frequently enough by the medical pro-

fession. Now, as in the past, it is far too common a practice to wait for definite symptoms, chest signs, or a positive sputum before an x-ray of the chest is contemplated or advised.

HOW TO OVERCOME THE SMOKING HABIT

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WE DO NOT plan to preach a crusade against the "vice of smoking" or to offer a panacea against the "nicotine poison" but merely want to propose a few common sense considerations and procedures. We will try to answer a question of the internist and the surgeon who complain that the condition of quite some patients—particularly vascular, cardiac and pulmonary ones—is affected adversely by excessive smoking.

Smoking is one means of satisfying, in part at least, the cravings for food. The whole process of sucking, chewing, biting and eating is a fundamentally pleasurable one. Nearly all peoples have developed ingenious ways of prolonging the satisfaction of feeding activities beyond those essential for swallowing the required amounts of food. The betel nut chewers of the Far East and the gum chewers of the West illustrate this point.

Use and abuse of tobacco belong to the countless habits which, despite their social-cultural background, show obvious relations to the constitution of the individual. There are, as only recently Wendt has demonstrated, people who apparently due to a certain constitutional sensitivity or idiosyncrasy are made so miserable through smoking that they are hardly tempted to develop it as a habit. One wonders whether or not many, perhaps the majority of women, belong here. These non-smokers play no role in our problem. Not all the idiosyncratic ones,

however, stay off smoking entirely; in those who do smoke, the exploration of their sensitivity and a clear explanation, if possible with experimental demonstration on themselves, can be most helpful.

Of real importance appear to be two large groups of smokers; for the sake of shortness we shall call them the lusty and the tense.

The lusty are the people with strong appetites who genuinely and thoroughly enjoy "all the good things of the earth" and with them smoking. They are possessed of completely healthy appetites for love and not infrequently for work as well as for eating and drinking. For every person who is not ascetic himself it is most refreshing to observe how these lusty individuals are able to devote themselves to the so-called sensual pleasures and not to them alone; how they enjoy quantitatively and qualitatively a choice meal, a fine drink, a good cigar, a well done play or concert. They prefer cigars and pipes to cigarettes, incidentally. For the lusty smoking means the satisfaction of one of a number of appetites. These appetites and their development are part and parcel of the lusties' constitution; their satisfaction is anchored constitutionally too.

The tense are fundamentally different from the lusty. *While the lusty have appetites to satisfy, the tense have tensions to relieve.* It does not seem to be necessary to give here a detailed description of the tense person; he is only too well known to every

physician and every physician is aware of the fact that the tension of these people is coupled with anxiety in most instances. The tense from early youth discover, rediscover and devise many ways to rid themselves of their often barely tolerable tension be it only for a short time. One of these ways is smoking—as a rule cigarette smoking. The picture of the tense cigarette smoker is familiar enough: he squeezes a package of cigarettes from one of his pockets; he picks a cigarette from the package; he puts the cigarette in shape rolling it between his fingers, tapping it on his thumbnail; he lights it in a hasty, somewhat ritualistic manner and then inhales the first pull with a half absent-minded, half ecstatic facial expression; on he goes spilling ashes around, manipulating his cigarette, finally either dropping the remaining stub contemptuously or burying it in an ashtray with some sort of a ritual. It must be noted that not all the tense experience even a passing relief from smoking; we are inclined to assume that not a few of the tense are idiosyncratic too and just increase their tension and feeling of misery when they smoke.

A classical example of the lusty was Doctor William H. Welch who into his eighties had enviable appetites and enjoyed his cigars. The full-fledged representatives of the lusty group very often do not need any antismoking treatment; they get old without showing ill effects of the satisfaction of their appetites. In those in whom vascular or cardiac disturbances make some therapeutic measure necessary, the introduction of “denicotinized” tobacco or cigars or of one of the reasonably working filter gadgets is recommendable. The lusty have little if any understanding for the ascetic, masochistically colored enjoyment that may be gained from resignation and renunciation—a factor which can be put to good use with not so few of the tense smokers.

A rather characteristic representative of the tense people smoking for relief was Mark Twain: he suffered greatly from irritability and poor sleep and was often advised to stop smoking and thus make himself a bit more comfortable or at least less uncomfortable. He seems to have been unable to find comfort with or without tobacco. He said, so it is reported, that to cease smoking was the easiest thing he ever did because he had done it a thousand times. This remark expresses the dilemma of the tense trying to quit smoking so clearly, that from it alone one could safely derive that Mark Twain was a tense person without having any other knowledge of his

personality. The tense usually cannot be induced to stop smoking unless one or the other of the main factors feeding and increasing their tension can be eliminated, e.g. too great pressure of work, marital difficulties, chronic disease. It is, of course, true that especially nowadays very many people, if not practically everybody, live under some tension; but it is also true that an intelligent adjustment or readjustment of almost anyone's life will mitigate or ameliorate some of the factors or conditions which arouse and increase tension.

Whatever one may do or advise, no pronouncement should be made suddenly. Everything must be discussed as deeply and broadly as the personality of the patient and the whole situation permit. It is imperative to achieve clear insight into the individual patient and into the background of his smoking habit. Here the histories of the tense are in general more interesting; they not rarely lead back to a rather early youth when the patient saw his tense father or mother or both his tense parents smoke and initiated them. If one can clear up such a background thoroughly and show the patient that his real goal—the relief of tension—is not reached through smoking at all or only very episodically, one may step by step help him to break his habit. One will be the more successful if he finds a method to relieve his tension fit for him, in other words if he learns how to relax.

Some of the tense—absurdly enough also certain tense with an idiosyncratic tinge—are the most difficult of all the excessive smokers in whom the acceptance of a filter may be the therapeutic peak. A professional man of unusual tension comes to mind whose thrombophlebitis was obviously and acutely made worse through his abuse of cigarettes and who worked out a method of his own which, at least for a time, did him some good: he would only take a few short pulls from every cigarette and then throw it away; this, of course, is just another filter method.

We know the case of another professional man who after many years of smoking in the fashion of the tense gave it up at once and completely when his friend and co-worker had to stop smoking on account of his health. To this gentleman, who in addition to very considerable tension had a clear cut ascetic strain in his make-up, the sacrifice for his friend meant more than the pseudo-relief of his tension through smoking. May it be mentioned in this connection that complete stopping of the smok-

ing habit, if deemed necessary, ought to be done on the ground of *one* decision of the patient and at once, not gradually. It depends on the skill of the physician step by step to bring the patient to the point where he, the patient, makes the decision and feels and shows the strength to stick to it.

Such drastic decisions cannot, in most instances, stand alone, but may require a rather comprehensive reorganization of a patient's life in which it is the natural task of his doctor to coöperate. This sounds pretentious, but it is true and feasible although it may not always appear to be worthwhile. We think of a third professional gentleman in a responsible position—a tense smoker who in later middle life had already suffered a couple of coronary attacks. He had often tried but failed to quit smoking. The untieing of a most unfortunate marriage by divorce relieved this patient of one important source of tension. He was then able to stop smoking. Six years have passed without coronary accidents and without return to the smoking habit. Not very often will it be possible to achieve such fundamental changes, but something or other can frequently be done that allows the patient some relaxation he lacked entirely before and perhaps a bit of satisfaction, e.g., from a hobby which was heretofore strange to his way of life.

The causes and reasons for which the tense come to smoking may not be vital. As mentioned the tense often smoke because they have seen older people smoke and develop the opinion—this pertains to the female almost as much as to the male sex—that it belongs to the obligatory behavior-patterns of the masculine, the smart and the grown-up human being to adorn his or her face with tobacco leaves. Yet, not only do sons smoke because their fathers did;

there are also some who smoke just because their fathers did not smoke: these, most of whom might be labeled as “defiant ascetic,” would be disgusted with their own moralistic attitude would they follow the example of their non-smoking progenitors. They are tense without exception.

It is a pretty common psychiatric-clinical experience to see episodic increase and decrease of tobacco consumption on a considerable scale as indicative, indeed symptomatic, of a psychiatric disorder. The tragic development of a writer became known who apparently all of a sudden stopped smoking to his great gratification; he went so far as to pat his own back for this achievement in a magazine article. A few months later he committed suicide as it seems in a condition of agitated depression.

SUMMARY

People develop and may abuse the habit of smoking tobacco in an effort to satisfy one of a number of appetites or in an attempt to relieve tension or on an imitative basis in conforming to a social pattern. There are, of course, tense individuals with outspoken appetites and imitation plays a certain role in all smokers since in a society in which smoking is unknown the lusty and the tense do not smoke either.

If the physician wants to help a heavy smoker to break the habit, he has to get as exact knowledge as possible of the patient's personality and ways of life. Then the doctor can in coöperation with the patient try to work out a more or less individualized method which will promise the more success the more the patient gains insight into himself and the very roots of his smoking.

WHAT WE CAN LEARN FROM GASTROSCOPY

JAMES FLEXNER, M.D., *New York*

The Author. B.S. *University Chicago, 1928*; M.D. *University Tennessee, 1934*; Assistant Physician and Chief of Gastroscopy Clinic, *New York Post-graduate Hospital*

GASTROSCOPY has become an important addition to routine gastrointestinal studies. The popularity of this procedure dates from 1932 when the present practical form of the flexible gastroscope was perfected by Schindler and Wolf.¹ The advantages of gastroscopy with this instrument are its high degree of safety, lack of serious discomfort to the patient and the large area of gastric mucosa which may be inspected by the examiner.

Schindler² found in response to a questionnaire that the fatality in 22,351 gastroscopies by 60 gastroscopists was only 0.004 per cent. He also observed that the reactions to pontocaine anaesthesia are negligible but occasionally there are grave complications in cachetic patients. These toxic manifestations are counteracted by intravenous barbiturate administration.

The distress associated with the gastroscopic examination is hardly more than that encountered in gastric aspiration and usually preferable to the relatively prolonged duodenal drainage. In the hands of a trained gastroscopist, the procedure is successful unless lack of coöperation bordering on psychopathy is present.

The pylorus is visualized in about 95% of the examinations and failure to see the pylorus usually indicates an unsuccessful examination. Small portions of the lesser curvature of the antrum, the posterior wall of the body and the lesser curvature of the fundus represent the blind spots in gastroscopy. In the presence of a neoplasm, however, this is a relative condition as the deformity frequently bulges into view.

In general, gastroscopy is indicated in all patients with chronic dyspepsia. It is particularly important when pain, indigestion, weight loss, hemorrhage and anorexia have been inadequately explained by other

methods of gastrointestinal investigation. The results of gastroscopic examination in this group of patients may reveal gastritis, previously undemonstrated neoplasm or ulcer, mucosal hemorrhage or a normal gastric mucosa. This additional information crystallizes the data at hand indicating the correct medical or surgical treatment or exonerates the stomach and directs further investigation to other abdominal viscera. When x-ray has demonstrated a gastric lesion, gastroscopic examination is of great value. In the differentiation between benign and malignant lesions direct inspection, while not infallible, is most helpful. The nature and extent of neoplastic involvement may be determined, also revealing the relative operability of the lesion. This information can be a real aid to the surgeon in planning the particular type of operation best suited for the case.

Perhaps the most important value of gastroscopy is its prompt use in patients over 40 years of age with the onset of digestive symptoms. The chance of an early diagnosis of cancer of the stomach is excellent. If patients in this group have an atrophic gastric mucosa they should be re-examined at intervals of three to six months.

Gastroscopy is the best means of following the healing of gastric ulcers and is helpful in following the response of patients with gastritis to general and specific therapy. The procedure is also an aid in following patients post-operatively as information can be obtained as to the mechanical adequacy of the artificial opening, intactness of the gastrointestinal margin and degree and type of inflammation of the mucosa.

All of these problems have been specifically encountered in the 475 examinations which we have performed in the past year and a half. Recently, two elderly patients were examined, upon whom the x-ray diagnosis of gastric polyposis was made. In the first patient no evidence of gastric polyps was found by gastroscopy but a marked chronic atrophic gastritis could be demonstrated. This patient was

spared an unnecessary laparotomy. In the second patient a nodular irregular polypoid mass could be visualized on the posterior wall of the body of the stomach. On operation in the second case the mass could not be palpated through the stomach wall but was found and resected after opening the stomach. Gastroscopecally the lesion seen in the second patient appeared malignant; histologically the tissue excised was benign. Obviously the prognosis in this patient is excellent while delay for clinical observation may have allowed changes which are commonly associated with malignant disease and a very poor prognosis.

In an 86 year old woman with x-ray evidence of a stenosing neoplasm of the stomach, gastrostomy or gastroenterostomy was considered as a palliative procedure. On gastroscopy, however, a definite demarcation of the upper limits of the tumor could be seen. In the absence of metastases, this type of lesion is amenable to resection. The latter procedure was successfully carried out.

A 57 year old emaciated man complained of severe abdominal pain and vomiting. A large hard mass could be felt in the epigastrium. Gastrointes-

tinal series revealed a large dilated stomach with almost complete retention and 50 per cent still retained in 24 hours. Gastroscopec examination after careful lavage the night before, revealed the pylorus contracting smoothly and rhythmically. The entire gastric mucosa showed characteristics of chronic atrophic and superficial gastritis. These findings suggested that the palpable mass was probably pancreatic or retroperitoneal in origin with no gastric involvement. Laparotomy confirmed this conclusion disclosing a large carcinomatous mass in the body of the pancreas.

These experiences are but a few of many³ in which gastroscopy has contributed important diagnostic data. The procedure should be included in routine gastrointestinal investigation and is indispensable to patients in the cancer age.

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LARGE BOWEL CANCER

PROSPECT FOR PATIENTS WITH LARGE BOWEL CANCER IN CONNECTICUT

A. W. OUGHTERSON, M.D., Chairman, *New Haven*

THE PROSPECT for the patient afflicted with cancer is of great importance not only to the patient, his family and relatives, but also to the physician and the medical profession, as well as society, represented by the various social agencies involved in the care of the patient.

One of the most common questions asked by the patient or his family is, "Will he survive the operation and what are his chances of being cured?" In order to answer this question many factors must be evaluated.

The information on which to base such judgment has been obtained mostly from large and specialized clinics and there is very little data available from the average community. The Tumor Clinics of Con-

necticut have now collected data which should yield information as to the prognosis for the cancer patient in this State. Time did not permit collecting data from all of these clinics, consequently the committee decided to collect records from the three Cities of Hartford, Waterbury and New Haven. This is the first time that such a coöperative study of cancer has been attempted in this State. It is anticipated that in the future studies of cancer in various parts of the body will be presented before these meetings.

WHAT HAPPENS TO THE PATIENT WITH CARCINOMA OF THE COLON AND RECTUM?

WILLIAM MENDELSON, M.D., *New Haven*

The purpose of this presentation is to reveal the fate of patients with carcinoma of the large bowel

and rectum; to emphasize certain well known facts by graphic means; and finally to attempt to draw constructive conclusions therefrom.

The material for this paper was generously contributed by members of the staffs of seven hospitals in Hartford, Waterbury and New Haven.¹ It represents all the cases of proven cancer of the colon and rectum known to these hospitals during the years 1930-1937. These cases were pooled to create a master chart and consequently represent a group of unselected cases of this phase of the cancer problem as it exists in the State of Connecticut. It does not, however, represent the total disease occurring in the community since only those cases entering hospitals are recorded.

Chart I shows that 604 patients with carcinoma of the colon were admitted to these hospitals. Of these, 496 were operated upon. The operations performed were of a radical, palliative and exploratory nature. Only 257 (or 42.5%) of the patients were submitted to the radical procedure which was performed according to a variety of techniques. Of this group, 171 patients survived and were able to leave the hospital. After three years, 86 patients were still alive and after five years this figure had dropped to 45 (or 11.4% of the original group).² Chart II presents a similar picture for cancer of the rectum.

The first conclusion is an obvious one; the outlook for a patient with carcinoma of the colon and rectum is discouraging. However, it must be remembered that these charts represent unselected cases and portray a more pessimistic picture than is ordinarily reported in the literature for selected groups.

It is also obvious that there is an unduly large number of patients who are admitted to the hospitals and are not operated on. This figure is 18% (108) for colon and 22% (182) for the rectum. The disease in these patients was so far advanced that operation was impossible. It is again a striking example of DELAY.

Since radical operation does offer a good chance

CANCER OF THE COLON FATE OF ALL PATIENTS ENTERING 7 HOSPITALS IN HARTFORD, WATERBURY & NEW HAVEN 1930-1937

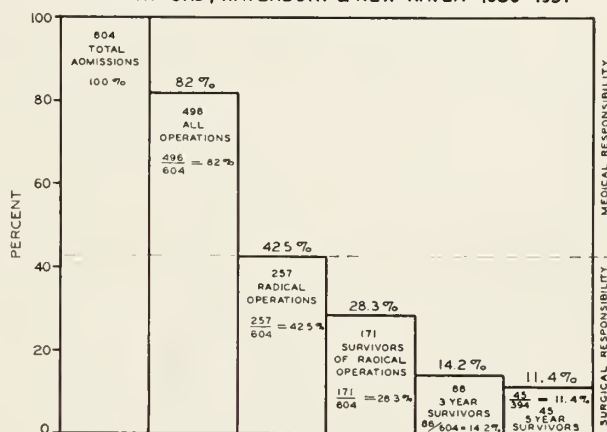


CHART I

CANCER OF THE RECTUM FATE OF ALL PATIENTS ENTERING 7 HOSPITALS IN HARTFORD, WATERBURY & NEW HAVEN 1930-1937

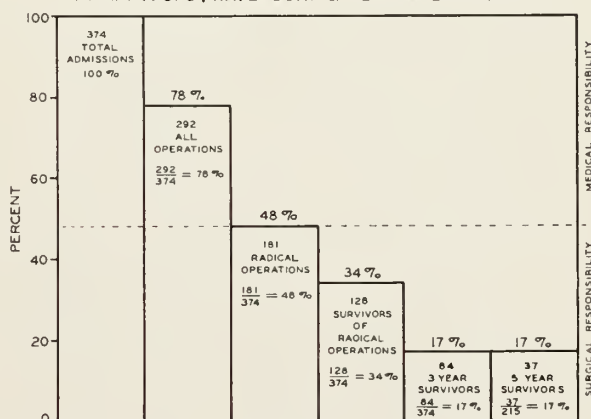


CHART II

of curing the disease, it is disheartening to observe that 58% (347) of patients with carcinoma of the colon were denied this chance. Similarly, 52% (193) of patients with carcinoma of the rectum fall into this group.

This is clearly a Medical Responsibility which must be met. It is the same concept of delay again and again. Part of this delay is due to the patient's failing to recognize the symptoms and this must be met by a more intensive educational program. Another part of the delay is due to failure to make a diagnosis, chiefly because modern diagnostic methods are not used early in the course of the disease. Something must be done to give these

1. Hartford—Doctor Robert A. Osmond, Hartford Hospital; Doctor Benedict Landry, St. Francis Hospital. Waterbury—Doctor Royal A. Meyers, Waterbury Hospital; Doctor Joseph Burke, St. Mary's Hospital. New Haven—Doctor Ashley Oughterson, New Haven Hospital; Doctor Joseph Russo, St. Raphael's Hospital; Doctor William Mendelsohn, Grace Hospital.

2. This figure is based on actual number of five year survivals for the 394 patients admitted from 1930-1935.

patients a chance and it is up to the medical doctor to assist them.

The Surgical Responsibility is indicated in the mortality figures and as techniques improve so will the mortality rate decrease. However, the surgeon cannot increase the five year survival figure unless the number of radical operations is increased.

The ideal chart of the future, say five years or ten years hence, should show the number of total operations approaching the total admissions, and similarly, the total *radical* operations approaching the total operations. With the inevitable increase in the total number of survivors after radical operations, the number of five year survivors would rise correspondingly. This is the goal of the Tumor Clinics in Connecticut, and with the coöperation of our medical profession and an intensive educational program there is every indication that it is possible of achievement.

WHAT MAY BE ACCOMPLISHED IN THE TREATMENT OF CANCER OF THE COLON AND RECTUM

A. W. OUGHTERSON, M.D.

The previous paper has indicated the prospect for the patient with cancer of the colon and rectum in Connecticut. It is likely that these figures representing seven hospitals in Hartford, Waterbury and New Haven are fairly representative of the State.

There are very few studies of a similar nature which are available for comparison since the majority of operability and mortality figures are obtained from large specialized clinics. However, such studies as are available indicate that the results in Connecticut compare favorably with other similar communities. An operability rate of 42.5% was found for the colon and 48% for the rectum (Table I). While the percentage of patients on whom a radical operation for cure is performed is lower than it should be, nevertheless it compares favorably with many of the large clinics. Many operability rates for radical operation are computed on the basis of the total patients operated on rather than the total patients seen with the disease. This gives an artificially high operability rate. For example, the radical operability in Connecticut based on the total number of patients in hospitals with cancer of the colon is 42.5% whereas if it is computed on the basis of only those patients having operations it is 50%. It should also be pointed out that operability

TABLE I
OPERABILITY RATES AND OPERATIVE MORTALITY

AUTHOR	COLON		RECTUM	
	RADICAL OPERABILITY	MORTAL- ITY	RADICAL OPERABILITY	MORTAL- ITY
Connecticut	(1) 42.5%		(1) 48%	
7 hospitals	(2) 50%	34.3%	(2) 62%	30%
F. W. Rankin	58%	12.3%	71.4%	11.8%
D. C. Balfour	50%	11.8%		
David Cheever	55%	17.6%		
D. P. Wilkie	55%	14.8%		
H. Finsterer	77.6%	20.4%		
D. F. Jones			(3) 63.5%	18.9%
W. B. Gabriel			(4) 41.6%	11.6%
St. Mark's Hospital			(5) 54%	
W. E. Miles			35%	12%
F. A. Collier			50%	18.8%
F. H. Lahey			53%	13.6%
Detroit Hospitals				
H. C. Saltzstein &	54.2%	51.7%	42.4%	48.7%
D. J. Sandweiss				

(1) Based on total patients entering hospitals.

(2) Based only on patients having some type of operation.

(3) Based on total patients seen.

(4) 1910-1921.

(5) 1921-1931.

rates in most large clinics have been steadily rising in recent years as better techniques have been developed. For comparison some of the operability rates reported are shown in Table I. The radical operability rates in these seven Connecticut hospitals would seem to indicate that as general hospitals they are doing extraordinarily well and compare favorably with the larger, more specialized clinics. It would appear therefore that while the indication for radical operation may be somewhat extended in these hospitals no great gain can be expected from this source unless more operable cases can be obtained.

The operative mortality as seen in Table I is higher than is recorded for the larger and more specialized clinics. This is to be expected as it has been clearly demonstrated that such major operative procedures are more likely to be achieved with a low mortality in proportion to the experience and specialization of interest of the surgeon. The operative mortality for cancer of the colon and rectum in these hospitals appears to be about twice as great as may reasonably be expected. The range of operative mortality is shown in Chart III, the highest for cancer of the colon being 50% and the lowest 15.7%. For the rectum the highest was 55% while

one hospital with only three cases had no operative deaths. However, if the operative mortality had been 15% for both the colon and rectum, 47 more patients would have survived operations on the colon and 26 more would have survived operations on the rectum. Nevertheless if they had all survived five years, it would represent an increase of only 7% for the colon and 7.7% for the rectum. While the surgeons should assume the responsibility of lowering the operative mortality, nevertheless the problem is still chiefly one of medical diagnosis.

There is too frequently a pessimistic attitude toward any operation on cancer of the large bowel. The question as to prognosis is always an important one. Charts IV and V illustrate some of the many factors which enter into the life expectancy of a patient who has cancer of the large bowel. It is seen that the stage of the disease, i.e., whether the cancer is localized to the bowel or has metastasized to the lymph nodes, is of great importance. While this is undoubtedly influenced by the pathological grade of the tumor, nevertheless the time at which the diagnosis is made, is the single most important factor. Even though a radical operation may be successfully performed it cannot be considered as a curative operation unless the tumor is diagnosed sufficiently early so that it may be entirely removed.

The future and experience alone can determine how much improvement may be expected in the treatment of cancer of the colon and rectum in Connecticut. It is clear that at present we are not making the best use of the methods that are now available. It is the function of the tumor clinics to suggest and assist ways and means by which improved treatment of these diseases may be accomplished.

HOW TREATMENT OF CARCINOMA OF THE COLON AND RECTUM MAY BE IMPROVED

JOSEPH F. BURKE, M.D., *Waterbury*

The first paper presented a graphic representation of the results of treatment of a series of cases in Connecticut hospitals. Although comparing well with other similar groups, the percentage of three and five year cures is small and the picture is gloomy. It seems clear that of the number of cases admitted to hospitals there is an unduly small number undergoing radical operative treatment. Less than fifty per cent in both groups, colon and rec-

CANCER OF THE COLON & RECTUM RADICAL OPERATIVE MORTALITY 7 HOSPITALS IN CONNECTICUT

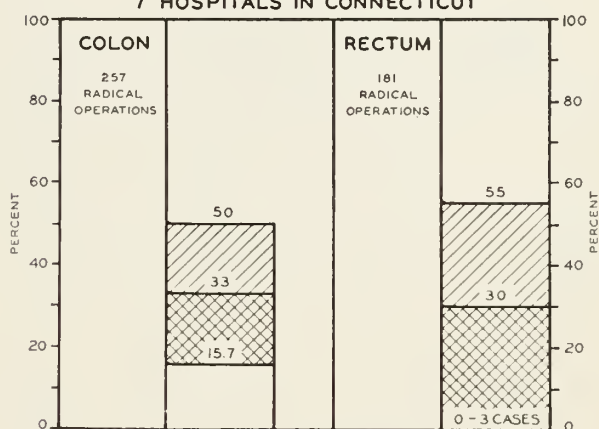


CHART III

Showing highest, lowest and average operative mortality by hospitals.

COLON-RADICAL OPERATION LIFE EXPECTANCY

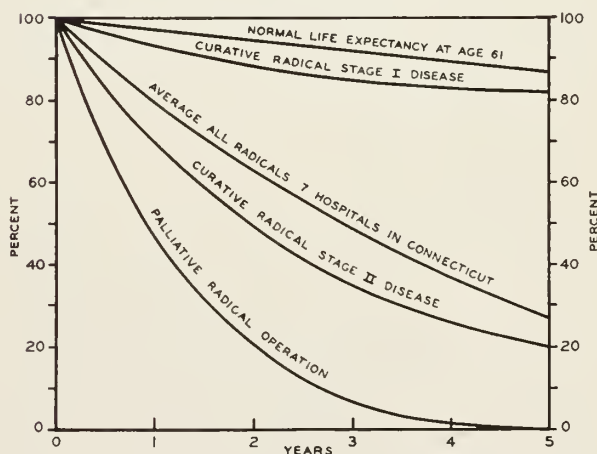
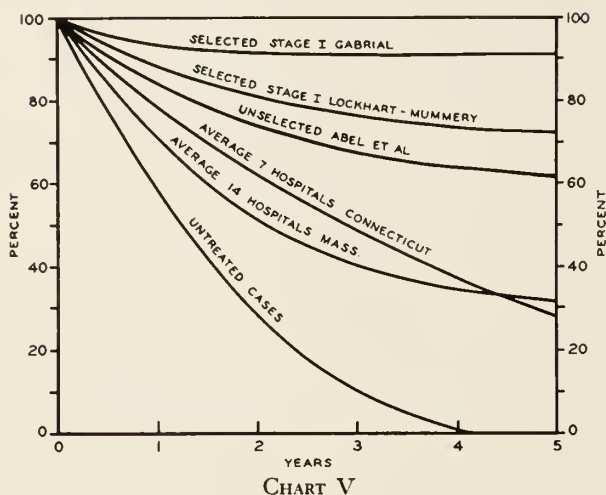


CHART IV

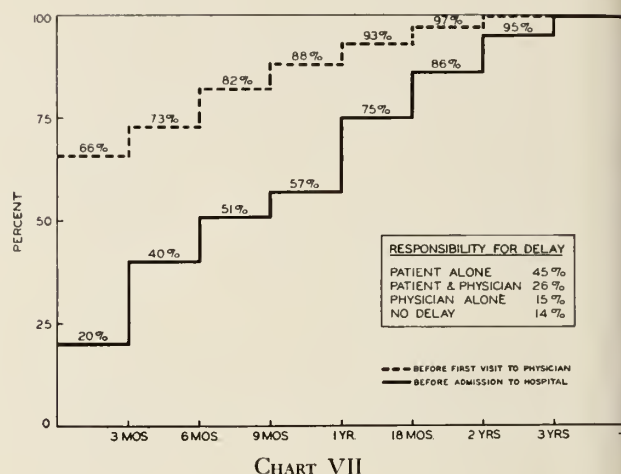
tum, underwent a radical operation (Charts I and II). The major part of this loss is due to inoperability on admission, while a small percentage is due to the refusal of patients to undergo surgery. Some few died within the first few days from obstruction, perforation or extensive metastases before any treatment could be instituted. Most of this group had palliative operations or x-ray therapy.

The reason for such a large degree of inoperability is delay, either in diagnosis or in surgical intervention. There are several components in this delay factor, a proper appreciation and correction of

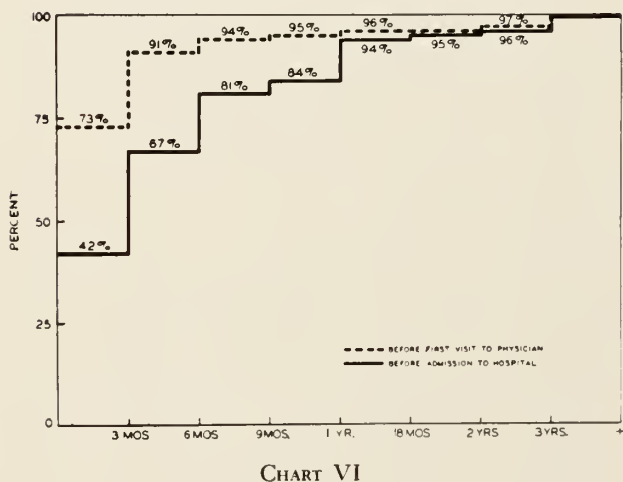
RECTUM-RADICAL OPERATION LIFE EXPECTANCY



DELAY IN DIAGNOSIS OF CANCER OF THE RECTUM



DELAY IN DIAGNOSIS OF CANCER OF THE COLON



which would go far toward changing for the better the picture which we see today.

The main components of the delay factor are patient delay and physician delay, or a combination of both. It is difficult to allocate the degree of responsibility in either case but Chart VI is shown in an attempt to demonstrate graphically the relative proportions of delay responsibility.

This graph depends on the careful questioning of a series of cases and the resultant figures may vary slightly according to the memory and veracity of the individual patient. But it does give a fair idea of the proportion of responsibility. As shown, 73% of patients with carcinoma of the colon saw a physician within three months of the onset of symptoms. Even

this is far too great a lapse of time and the patient is entirely responsible for it. Ninety-one per cent had seen a doctor within six months and a few allowed nine months to three years to pass. The solid-line graph shows that 42% of the cases seeing a doctor within three months were sent to hospitals within that time. The difference between 42% and 73% is the proportion of delay that must be attributed to the physician or to the patient and physician combined in the three month period. Likewise in the six month period only 67% of the 91% of cases consulting a physician were admitted to hospitals.

Chart VII illustrates the same breakdown of the delay factor in the cases of carcinoma of the rectum. The delay of patient and physician is even more marked than in the colon series. It would appear that the symptoms in the rectum bring themselves to the attention to both parties much more slowly. Only 66% of cases saw a physician within three months of onset of symptoms, and only 20% of these were admitted to hospitals in this period. Swinton and Warren reporting 300 cases at the Lahey Clinic in 1938 estimated the average span between onset of symptoms and resection to be nine months.

The largest delay is found on the part of the patient, and at first glance it is difficult to understand how three to nine months are allowed to pass before consultation with a physician. But it must be remembered that bowel irregularities, spells of constipation, diarrhea or bleeding hemorrhoids are more or less expected and taken as a matter of course by the majority of the laity. Self-medication for such

complaints has always been rampant. The possible dangers of such symptoms and of self-medication are not realized by the public. Education of the people may appear difficult and discouraging but it is certainly possible. This is demonstrated by the readiness with which they learn from radio announcements that in order to improve "faulty elimination" one must take patent medicine A and the pernicious doctrine that after the age of thirty-five it is to be expected that the intestinal muscles will not function so well and that the remedy is patent medicine B. All kinds of similar nostrums are readily sold by repeated commercial plugs. The medical profession can and should do likewise. In regard to cancer of the colon and rectum, it should be repeatedly stressed in radio broadcasts, magazines, and newspapers, that any change of the normal bowel habit may be the earliest sign of the disease for which the patient should seek the advice of his physician.

Another factor of patient delay is the refusal or inability to pay the necessary money for x-ray and sigmoidoscopic examinations. In such cases, the suspicions of the doctor must be frankly stated and the patient shown that the reassurance of a negative examination is worth the money, and that an early positive finding gives the best chance for continued health. Lack of funds is not too marked an obstacle since we have many clinics which will furnish services at low cost and, in fact, any of our radiologists are glad to coöperate in such cases. Frequently after diagnosis is made, the fear of a permanent colostomy gives rise to another delay. The patient will sometimes also avoid diagnostic procedures in the fear of a positive finding. Increased early diagnosis may save the patient from a radical operation. Polyps, so often the precursor of cancer, may be fulgurated or removed by snare. Early lesions might be resected with better esthetic results. Future colostomy patients may be influenced in the decision for or against operation by the degree of satisfaction and comfort shown by present colostomy patients. It is, therefore, necessary not to neglect the aftercare of colostomy patients. They should be seen frequently and taught to protect the skin against irritation, to take regular bowel irrigations, and to regulate the diet, and in many small ways make the existence of the patient bearable. The present state of colostomy patients is far better than it was in the past. The bowel is kept relatively empty and dry, a flat pad and narrow belt are used instead of the former

CARCINOMA OF THE COLON (EXCLUDING RECTUM) INITIAL AND ADMISSION SYMPTOMS

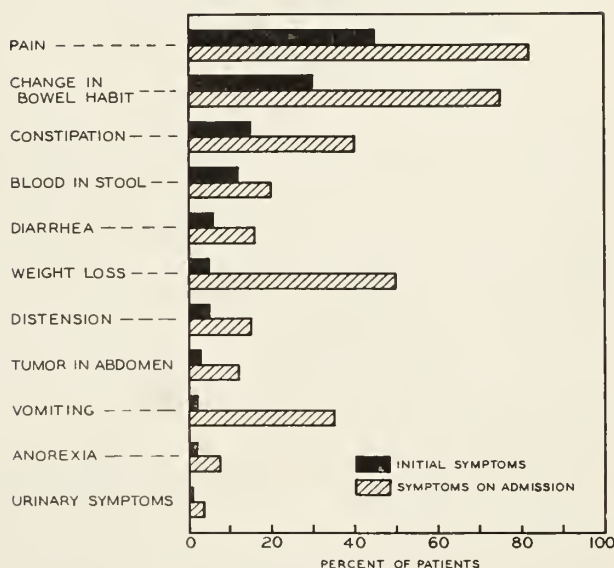


CHART VIII

cumbersome and odorous colostomy bag. All these lesser points are emphasized in-so-far as they have a definite part in removing the despair of the patient who faces the choice of a radical operation.

Physician responsibility is still present as demonstrated in Charts VI and VII. The main factor is probably the failure to pay enough attention to the early symptoms, and neglect in ordering x-ray and sigmoidoscopic examination or even in performing a digital examination.

Chart VIII illustrates the incidence of various presenting symptoms as compared with total admission symptoms. In this series, pain is the outstanding symptom, with a change in the bowel habit and constipation following in order. Early symptoms vary in incidence in various series. The before-mentioned series of Swinton and Warren show the presenting symptoms to be (1) altered function in 80%; (2) cramps and pain in 57%; (3) blood in stool in 46%. The problem of carcinoma of the bowel is really the physician's more than the surgeon's. He sees the patient first, usually, and if the percentage of salvage in these cases rises in the future, the credit must be given to the physician for earlier diagnosis.

In regard to the early diagnosis of colon cancer, I would like to emphasize that the disease cannot be diagnosed early by signs and symptoms. If the symptoms are marked enough for certain diagnosis, it is already too far advanced to be helped by sur-

gery. Laboratory aids and particularly x-ray are required for early diagnosis. The absence of blood in the stool is not significant. Early lesions may not be ulcerated or bleeding.

X-ray study is invaluable but it must not be forgotten that lesions in the rectum may not be seen in the barium enema. Cattell speaks of a case of diarrhea having barium enemata at six and nine months after onset of symptoms. Both examinations were read negative. Digital examination at fourteen months showed an easily felt, extensive carcinoma of the rectum. There must be many such cases in which a negative x-ray has lulled the physician's suspicions. He must, therefore, insist on digital and sigmoidoscopic examination.

It has been shown that about 60% of patients with carcinoma of the rectum have hemorrhoids and that 50% of the patients with cancer of the rectum have had treatment for hemorrhoids, 30% self-medicated, and 70% treated by doctors. Fifteen per cent were originally diagnosed and treated as colitis. This is one of the worst aspects of the delay problem. In these cases, we see the patient but do not heed the warning. Hemorrhoids, therefore, should never be

treated without first doing a digital and sigmoidoscopic examination. Seventy per cent of carcinoma of the large bowel occurs in the rectum and rectosigmoid and most of these can be reached by the finger and proctoscope. In failing to perform these diagnostic examinations, we are saving five or ten minutes of our time at the possible cost of years of the patient's life.

In summary, I would again say that the great obstacle to the successful treatment of bowel carcinoma is the delay factor. We must always keep in mind and in every possible way try to instill in the mind of the public that any departure from the usual bowel habit, be it pain, bleeding, constipation, diarrhea or both alternating, tenesmus, anaemia, weight loss without loss of appetite, or any ill-defined colonic symptoms, is fraught with danger. Such symptoms although not diagnostic should raise in our minds the possibilities of carcinoma and let us not rest until by every means at our command, we have ruled out this possibility. Persistence in this course will certainly make our future reports on progress and treatment of carcinoma of the bowel much more cheerful.

AVERTIN IN THE TREATMENT OF TETANUS

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THE Council on Pharmacy and Chemistry¹ accepted avertin with amylene hydrate in 1936. Avertin with amylene hydrate is now considered a safe basal anaesthesia. In the case to be reported a rather unusual opportunity was afforded to study the affects of prolonged avertin administration. We were interested particularly in the efficacy of avertin in controlling the neuromuscular hyperactivity in tetanus and in determining any evidence of liver

damage. It should be stated, that the present day tests for liver function are not entirely satisfactory.

CASE PRESENTATION

M.A. age 26, weight 82 kg. The patient was referred into the Grace Hospital on September 20, 1939, by Doctor S. B. Rentsch of Derby with the diagnosis of tetanus. He was a mechanic by trade and frequently received minor cuts and abrasions which for the most part were not of a magnitude requiring medical aid. There was noted at the time of admission a small superficial laceration on the dorsum of the right index finger measuring about one half cm. in length. This area had a crust over it and did not seem grossly infected. To the best of his knowledge, this cut was received about eight days before admission. Three days before entering the hospital he began to experience some stiffness of the neck muscles, although he continued to work. The spasm progressed to involve the jaw muscles, and after three days of

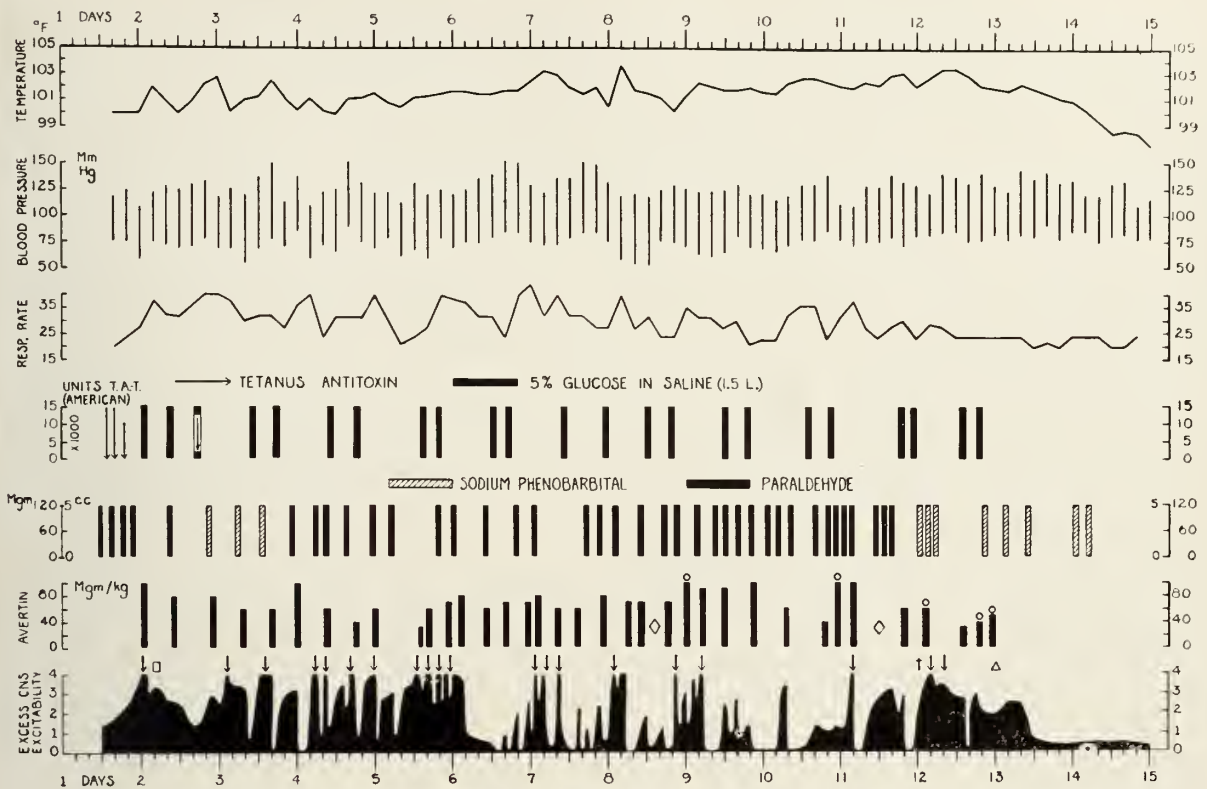


FIGURE 1

▼ Each arrow represents a series of severe convulsive seizures characterized by generalized tonic muscular spasm, opisthotonus and cyanosis lasting for thirty seconds or more.

□ Incomplete retention of avertin enemata.

◇ Urobilinogen tests.

□ Patient unconscious from this point until 12th day.

† Consciousness regained.

△ Taking food well by mouth.

delay he consulted the physician who referred him into the hospital.

The admission examination revealed marked rigidity of the neck, with severe spasm of the left sternocleidomastoid muscle drawing the head toward the left shoulder. The trunk was moderately flexed. There was marked spasm of the paravertebral muscles, especially in the dorsal region. He could open his mouth only slightly. No tonic spasms were noted, but there were some quick small muscle contractions at the angles of the mouth. The jaw reflexes were exaggerated but the tendon reflexes in the arms and legs were not hyperactive.

Within about six hours the full blown clinical picture of tetanus had developed. An intradermal sensitivity test was done which proved to be positive and the tetanus antitoxin was given in divided doses. Within the first 28 hours, 40,000 units (American) of tetanus antitoxin were injected intramuscularly, and 10,000 units intravenously. An attempt was made to control the extreme hyperexcitability of the nervous system by the rectal instillation of avertin with amylenehydrate, and by the intramuscular injection of paraldehyde or sodium

phenobarbital. The patient remained unconscious from the onset of symptomatic therapy with avertin until the eleventh hospital day. The nutrition, body water and electrolytes were maintained solely by means of intravenous infusions of glucose and saline. His body weight fell approximately 14 kg. On the fourteenth day, the patient complained of numbness in both small fingers and along the ulnar side of the hand and forearm. There was objective impairment of sensation and motor function in the dermatomes and muscles supplied by the ulnar nerves. X-rays of the cervical spine were taken which ruled out the possibility of a spinal injury as a cause for the peripheral nerve phenomena. A moderate serum reaction had occurred, and the symmetrical nerve involvement was interpreted as a neurologic complication of serum sickness. The patient was discharged on October 21, 1939, very much improved.

Figure 1 represents an attempt to demonstrate in a graphic fashion the course of the illness. The degree of success attained in controlling the nervous system excitability is depicted on an arbitrary scale

in the solid black area at the bottom of the figure. The zero line does not represent normality, but rather the absence of convulsive phenomena. Paraldehyde and sodium phenobarbital were considerably less effective than tribromethanol in giving symptomatic relief, but even deep anesthesia did not avert neuromuscular phenomena characteristic of tetanus. This suggests that tetanus convulsions differ in point of origin from those produced by convulsant drugs. Harvey² has shown that the rigidity which is so characteristic of tetanus is not due to a central action of the toxin, but is dependent upon the integrity of the motor nerve endings in the muscle. His experiments afford direct experimental evidence of a peripheral action of tetanus toxin in the region of the neuromuscular junction.

Over a period of 12 days, 38 injections of paraldehyde were given (190 cc.), 11 of sodium phenobarbital (1.3 grams), and 36 doses of avertin totalling (exclusive of enemata in part expelled) 2070 mgm. per kg. or 170 grams. Despite the large amounts of

avertin, urobilinogen tests revealed no liver damage, and bromsulphalein dye excretion tests performed on the twenty-second and twenty-ninth days of the illness gave normal figures. The cardiovascular and respiratory systems were not untowardly affected by the large amount of depressant drug given.

SUMMARY

1. A case of tetanus is reported.
2. No evidence of liver damage was detected in spite of prolonged administration of avertin with amylene hydrate.
3. Some clinical evidence is derived from this case to support the theory that tetanus toxin has a peripheral rather than a central action.

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MORTALITY IN DIABETIC COMA

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The Author. M.D. Yale 1921. Chief Attending Physician, Lawrence & Memorial Associated Hospital, New London

DURING the last year an investigation was made to determine whether the number of deaths resulting from diabetic coma in this hospital was higher than it should be. While the investigation was in progress an article on the subject of diabetic coma by Doctor I. M. Rabinowitch appeared in the *Annals of Internal Medicine*. In his article Doctor Rabinowitch set up certain criteria for the study of diabetic coma which seemed worthy of emulation and in my study I have attempted to adhere to them. Not having at hand all of the data available to Doctor Rabinowitch I have made minor modifications of some of his tables.

The definitions employed by Doctor Rabinowitch for the stages of coma are as follows:

Threatening coma: Ketone bodies in the urine and reduction of the CO₂ combining power of the plasma, and clinical signs suggestive of coma (Kussmaul respirations, vomiting, but no drowsiness; the patient is quite conscious).

Coma: The signs of threatening coma plus drowsiness or a greater degree of unconsciousness, thus:

Stage 1—Drowsy.

Stage 2—Semi-conscious.

Stage 3—Unconscious but responds to pain.

Stage 4—Completely unconscious.

Doctor Rabinowitch feels that the more important factors which must be taken into consideration in the interpretation of mortalities from diabetic coma include (1) the clinical criteria for the diagnosis of coma, (2) the level of the CO₂ combining power of the plasma, (3) age, (4) the duration of the coma, (5) the degree of unconsciousness, (6) the blood-pressure, (7) the degree of renal impairment,

From the Medical Service of the Lawrence and Memorial Associated Hospitals, New London, Conn.

and (8) the associated conditions or complications other than renal failure which can, per se, cause death. Other, but less definite variables appear to be the concentration of sugar in the blood and the degree of leucocytosis.

Doctor Rabinowitch's table showing the relationship between the degree of unconsciousness and mortality follows:

STAGE	MENTAL STATE	NUMBER OF		DEATHS
		CASES*	NO.	%
1	Drowsy	60	8	13.3
2	Semi-conscious	37	6	16.2
3	Unconscious but response to pain†	13	7	53.3
4	Completely unconscious	11	11	100.0

*Four cases are omitted-descriptions are not sufficiently specific for classification.
†Elicited by touching conjunctivae.

During the last five years twenty-five patients were admitted to this hospital in diabetic coma of which five died. The relationship between the degree of unconsciousness and mortality is shown in the following table:

STAGE	MENTAL STATE	NUMBER OF		DEATHS
		CASES	NO.	%
1 & 2	Drowsy and semi-conscious	15	2	13.3
3 & 4	Unconscious but response to pain and completely unconscious	10	4	40.0

Stages 1 & 2 and 3 & 4 are combined in this table because of lack of detailed data.

The relationship between age and mortality in Doctor Rabinowitch's series is as follows:

AGE PERIOD	NUMBER OF		DEATHS
	CASES	NO.	%
-20	88	3	3.4
21-30	21	4	19.0
31-40	26	3	11.5
41-50	28	7	25.0
51	37	17	45.9

The relationship between age and mortality as found in this hospital follows:

AGE PERIOD	NUMBER OF		DEATHS
	CASES	NO.	%
1-10	1	0	0.0
11-20	5	0	0.0
21-30	0	0	0.0
31-40	4	0	0.0
41-50	3	1	33.3
51-60	8	3	37.5
61-70	3	0	0.0
81-90	1	1	100.0

Abstracts of the histories of the fatal cases follow:

(1) Female, aged 53. Known diabetic for many years. On 60 units of insulin daily and indiscreet as to diet. Felt ill for twelve hours prior to admission. Vomited several times. Collapsed and pulseless on way to hospital. Admitted in acute respiratory distress but conscious, nervous and apprehensive. Heart sounds distant and rapid. Urine showed acetone 4 plus and sugar 4 plus, no diacetic acid. Died one hour after admission.

(2) Female, aged 50. Patient had in addition to the diabetes severe thyrotoxicosis. Was admitted in coma of 48 hours duration and with a temperature of 96, pulse 140 and fibrillating. Kussmaul breathing, soft eye-balls and dehydration were present. Blood-pressure 112/60 Blood sugar 444 mgm. Urine showed 4 plus sugar, trace of acetone and diacetic acid. Died within twenty-four hours without regaining consciousness. On the day of death the urine was free of acetone bodies.

(3) Male, aged 56. Had had diabetes for many years. Was also a chronic alcoholic. Had been drinking large quantities of alcohol and had been unconscious for four hours before admission. Had all of the classical signs of diabetic coma. Blood-pressure 80/50 and pulse rate so rapid as to be indeterminable. Urine showed albumin 2 plus, sugar 3 plus, acetone and diacetic acid four plus. Became conscious enough to respond to questions for a short time but died forty-eight hours after admission. On the day of death the urine showed sugar 3 plus, acetone 4 plus, diacetic acid 0.

(4) Female, aged 59. Had had symptoms of diabetes for two years but disease had been diagnosed only five days before admission. Ten days before admission had developed sore throat associated with swollen cervical and inguinal nodes. On admission temperature 102, pulse rapid. Exudate in pharynx, heart enlarged to left and downward and fibrillating. Urine showed sugar, acetone and diacetic acid all 4 plus. Blood sugar 400 mgm, non-protein nitrogen 30 mgm. The day after admission was still semi-comatose but heart was regular. Blood sugar had dropped to 74 mgm. Became comatose two days after admission, temperature rose to 105, pulse 140, respirations 44 and death ensued. On the day of death urine showed sugar 2 plus, acetone and diacetic acid 0.

(5) Male, aged 81. Had been a mild diabetic for years. Diabetes had been controlled by diet. For five days prior to admission had been unable to void because of prostatic hypertrophy, necessitating catheterization. During this period was restless and irrational. Went into coma a few hours before admission. On admission heart rate was rapid and there were many extra-systoles. Urine showed sugar 4 plus, acetone 2 plus, diacetic acid 0. Seemed to improve slightly but died suddenly two days after admission.

The patients in this series were treated by a number of physicians, both general practitioners and internists. We have no diabetic clinic and all patients were admitted to the general medical service or to the care of their personal physicians.

THE ORIGIN OF THE CONNECTICUT STATE MEDICAL SOCIETY

CREIGHTON BARKER

WHO FIRST had the idea for a formal medical organization in the Colony of Connecticut will never be known, and the inquiry as to where the first medical society in the State was organized has resulted in varying opinions. The subject has received careful and reliable investigation by many medical historians, and no attempt will be made to state a conclusion here.

Priority of organization will probably be found in New London, Litchfield, or New Haven counties, and until additional information comes to light the facts appear to be as follows: There was a group of eleven physicians in Norwich and vicinity who organized themselves in October 1763 for the purpose of obtaining a charter for a medical society. After a fruitless attempt to accomplish this purpose, the organization dissolved. The medical society in Litchfield County has been the subject for much exciting study, and it has lately been clarified by a paper prepared by Walter Steiner. It is Doctor Steiner's conclusion that the Litchfield County Medical Society was organized on July 5, 1779, although the continuous existence of that Society since that date is not recorded, and there will always be in the background of this investigation the statement of Judge Samuel Church at the Litchfield County Centennial in 1851 that a medical society was formed in that County as early as January 1767. Where Judge Church obtained his information or how reliable it is remains to be determined.

The New Haven County Medical Society was founded on January 5, 1784. The minutes of that meeting and of every meeting since then still preserve an accurate record of that association's history.

There is an almost unknown but reasonably credible record of an effort to organize a medical society in New Haven County at a much earlier date. Indeed it is earlier than the Norwich or the Litchfield County experience. This record has been lost and only by the merest good fortune has any of it survived.

Leverett Hubbard was elected the first president of the Connecticut Medical Society at the meeting held in Middletown on October 9, 1792, and at the close of his first term in office (he served until 1794) on Wednesday the fifteenth day of May 1793 he presented a presidential address before the Society in the tavern of David Bull in Hartford. The manuscript of that address was preserved and came into the possession of Doctor Henry Bronson of New Haven, who was perhaps Connecticut's foremost medical historian. Doctor Bronson had the Hubbard manuscript in his possession when he

wrote the valuable monographs on medical history that were published by the New Haven Colony Historical Association about 75 years ago. He presented the manuscript and Leverett Hubbard's account book to the New Haven Colony Historical Association in 1877. The account book is still preserved and available for study, but recent careful search has failed to locate the Hubbard manuscript. No living person has ever seen it.

Through the generosity of members of Doctor Bronson's family some of his books and papers came into my possession, and among these documents is a single sheet of paper written by Doctor Bronson on which he quotes an excerpt from the Hubbard address. It has so much valuable bearing on the beginning of medical organizations in our State that it is here quoted in full in order that it may never again be lost.

"A medical society in the State was long in contemplation by the faculty, and in 1739 some of the most eminent met at New Haven for consultation. They recommended the faculty in general to meet the next year. They met at New Haven, Elliott, Mather, Bulkley, Hooker, Porter, Labore, Bull, Morrison, Hubbard, Harpin (?), Rogers, Gould, Hull, Wenham, and others. Doctor Jared Elliott was chosen chairman. They remained in session two days and deliberated on a plan but did not agree and adjourned without day." This may have been the earliest medical society idea in the Colony.

There is little question but the first organized attempt to obtain legislative approval of a medical society in Connecticut was made by the eleven physicians of Norwich in October 1763. The memorial was signed by Theophilus Rogers, Joshua Downer, Cyril Carpenter, Obadiah Kingsbury, Ebenezer Robinson, Joseph Perkins, Philip Turner, Elisha Tracy, Moses Morriss, John Barker, Elisha Lord. The petitioners prayed that the physicians in each county of the Colony might have the liberty to meet quarterly and to select annually "a committee of three approved physicians" to examine the candidates for the practice of physic and to approve by certification those found qualified, the rejected candidates to have the right to another examination at any quarterly meeting in the same county. The motive of these petitioners can probably not be determined at this late date, but that there was an underlying economic consideration is clear; for the petition also provided that physicians without certificate, not already in practice, were not to be allowed to collect their fees by law. The legislature of 1763 denied this petition.

After 1763 there were apparently frequent efforts at medical organization. 1764, '65, '66 have been uncertainly mentioned as years of forming of medical groups in Litchfield County. There are indefinite references to the revival of the Norwich movement on March 24, 1774 and the call for a meeting in Hartford on April 27, 1774. And finally there came the more productive attempt in Litchfield County on July 5, 1779 quoted by many. Doctor Steiner has traced it into the organization with the high sounding title of "First Medical Society in the Thirteen United States of America Since their Independence" that had its pretentious meeting at the invitation of Doctor Simeon Smith in Sharon in February, 1780.

Twenty years elapsed before another attempt was made to obtain a legislative charter for a medical society. On the tenth day of December 1783 a group of New Haven physicians, headed by Leverett Hubbard, advertised in the Connecticut Journal that a meeting of physicians would be held in New Haven on January 5, 1784, for the purpose of uniting "in petition with other county societies to the honorable legislative body for an act of incorporation the more effectually to regulate the practice of physic."

After the New Haven County Society had organized in 1784 and adopted its regulations and equipped itself for business, a committee of correspondence was appointed that consisted of its most distinguished members including William Gould, Eneas Munson, Jared Potter, Samuel Nesbitt, Ebenezer Beardsley, and Edward Carrington. These gentlemen addressed circular letters to prominent physicians in the different counties inviting them to send delegates to a general meeting to be held at "Mr. Butler's" in Hartford on May 19, 1784. It is recorded that Charles Phelps and Joshua Downer were appointed delegates from New London County for this meeting, and the committee of correspondence from the New Haven Society was to represent that County. They were authorized "to agree upon and organize a medical society, and to join in a petition to the legislature for an act of incorporation." There is no available record of the proceedings of the general meeting held in Hartford, but in August of 1784 the New Haven County Society appointed Doctors Munson, Beardsley, and Carrington a committee "to examine the doings of the committee at Hartford and to make such alterations as they shall think proper," and they were appointed to represent the committee at another general meeting to be held on the thirteenth of October at the house of Mr. John Miles in New Haven.

How many attended the October meeting may not be said for the records are lost, but the delegates appeared to have prepared a "petition and bill in form." The New Haven County Society took the responsibility for distributing these petitions, and on January 5, 1785, copies were forwarded to physicians in the several counties of the State and another meeting was called to be held in Hartford on May 18.

Some changes in the original petition were made, and the Convention of May 1785 agreed upon it in its amended form. The petition was presented to the House of Representatives at the two semi-annual sessions in May and October 1785, and the request of the petitioners was granted; but the Council, though favorably impressed, refused its sanction. It appears that the motives of the petitioners had been misunderstood, and a letter to Governor Huntington from the physicians' committee said "some ignorant and ill-minded persons have misrepresented our designs and insinuated that the main object was to increase the pecuniary emoluments of the faculty."

The New Haven County Society committee proceeded to revise the bill and delivered it to the various committees requesting that further efforts be made to obtain legislative approval, and a meeting was called for the sixteenth day of May 1786 at Butler's Tavern in Hartford for the purpose of organizing legislative strategy. It is interesting to note that propaganda was

employed in those early days, and at the May meeting it was resolved "to prepare and publish in the Weekly Gazette a history of some of the medical corporations of Europe and America, to state to the public the grounds and reasons which have induced the faculty of this State to request an act of the legislature incorporating a society." It was further resolved that members of the committee should write to some of the "principal characters" requesting their assistance. Governor Huntington's influence was also sought.

The committee of physicians carefully withdrew from any possibility of criticism because of monetary motives and prepared a new petition based solely upon consideration for the public weal and improvement of the quality of medicine.

The petition read in part: "In most of the neighboring legislatures of the United States, and in many other well-ordered governments, the encouragement of accurate study in the theory and practice of physic and surgery are estimated deserving the assistance and patronage of legislative authority, and the wisdom and policy of many enlightened nations have heretofore been happily exercised in establishments for the promotion of medical knowledge, and for the same purposes medical societies have been heretofore instituted under the sanction of government, and incorporated with such privileges and immunities as were consistent with the utmost liberality of sentiment and practice, highly useful to mankind, and of essential advantage to the profession and its practice, and to the establishment and continuance of such societies so incorporated as aforesaid." The petition spoke with pride of the "many important and useful discoveries in anatomy, chemistry and botany and the many accurate histories and cures of diseases which never would have been explained, methodized and publicly authenticated unless societies had been so established for the preservation and diffusion of medical improvement." The petitioners "are sensible that all useful knowledge is promoted by a liberal toleration in sentiment and practice, and by allowing the mind free scope in its researches," and asked no "restrictive power or exclusive privileges."

The bill closes: "Your Honors' petitioners respectfully approach your Honors, with wishes that their profession may be taken under your Honors' patronage and protection, and therefore pray your Honors to decree that there shall be in this State a medical society known and instituted by the name of the Connecticut Medical Society, with such charter, rights and privileges and act of incorporation as your Honors shall in your wisdom judge best calculated to promote medical knowledge and improvement."

This memorial was signed by Benjamin Gale, Leverett Hubbard, John Clark, Thaddeus Betts, Elihu Tudor, Thomas Coit, Ichabod Warner, and Joshua Porter. The Upper House considered it at the October session and again at the May session of 1786, and at the October session of 1787 it was referred to a joint committee of which Pierpont Edwards of New Haven was the chairman. The memorial was finally favorably received by this committee, and a bill was accordingly brought in that authorized the several county medical associations in the State to be known as "the established

medical conventions of the counties," they were to "convene annually to choose necessary officers, to make regulations for the admission of members, to anatomize the dead bodies of criminals and capital offenders with the permission of the court," and so forth. The same bill authorized a state society to be known as the "President and Fellows of the Connecticut Medical Society." The President and Fellows might admit members at their pleasure the whole number not to exceed 70, might appoint examining committees in the several counties who should certify to qualifications to practice, make by-laws relative to admission, expulsion, and "disfranchisement," might annex (?) reasonable fines and penalties to the breaking of by-laws not exceeding 20 shillings for such offense, but could not abridge the rights of any practitioner.

These were the important characteristics of the charter first sought by the Connecticut Medical Society. It passed the Lower House but was rejected by the Upper. During its consideration there is evidence that vigorous efforts were made by physicians of the State to secure its passage. When the bill finally failed the doctors of Connecticut were grievously disappointed and felt that a great calamity had befallen the profession and the public. It was a mystery to them why their honest labor in the cause of humanity and science should not be recognized.

What brought our forbears to the conclusion that nothing great or durable could be accomplished without the aid of legislation cannot now be answered, and why they did not proceed with a voluntary association without benefit of charter is not clear. This was especially true at this time when it was not customary to make laws for the benefit, or seeming benefit, of special classes or individuals. There was a well-founded apprehension of the danger which might come from special privileges and monopoly granted by the State. Indeed, in 1787, only a few cities had been incorporated, and there is no reliable evidence that a single private charter had been granted up to that time. Under these circumstances the position of the legislature is understandable, and it can be seen why it was reluctant to change its policy. More than this, there were privileges proposed in the rejected bill that could excite the jealousy of suspicious people, particularly those provisions of the act which gave to the incorporators and members the right to choose their associates and successors and the Society the power to professionally disfranchise physicians and impose fines for violation of its by-laws. Many phases of the history of the development of the Connecticut Medical Society have been investigated and written, but this one which has to do with the philosophy of these primary efforts to obtain a private charter has been neglected, except for a rather discursive analysis of the charter that was presented by Doctor Stephen Hubbard before the New Haven County Association in 1887. It offers a fascinating subject for legalistic inquiry.

With this defeat in the halls of state many became discouraged and it is recorded that the eastern counties became indifferent and apathetic to the proposal. The New Haven County Society, however, was not put back, and one suspects that it was constantly stimulated by the well-known stub-

bornness of Leverett Hubbard. Even before the defeat of 1787 the New Haven County group had directed their committee to open correspondence with societies in Europe for the purpose of increasing and collecting further medical knowledge. Then came the most daring propaganda step to be undertaken. In January 1788 the New Haven County Society appointed a competent committee to edit and publish valuable papers and case reports to be contributed by Connecticut physicians. The object was surely to make for themselves a reputation at home and abroad and increase their influence with the public and the legislature. The little volume entitled "Cases and Observations" appeared in the summer of 1788, and it was the first medical transactions to be published in America. Many books were received in exchange for this publication and from other sources, a library was established and a librarian appointed, and the New Haven County Society was freshly determined to seek a charter as an educational institution.

The controversy concerning chartering of a medical society waxed hot and was not confined to the profession but extended into public consideration. Yale College partook of the excitement, and on the fifteenth of July 1788 the seniors discussed the question "Whether It Be Safe to Grant the Proposed Charter of the Connecticut Medical Society," and President Stiles in his diary reported a debate on the sixth of January 1790 on the question "Whether the Institution of Medical Societies Be Useful."

The next attempt at attaining a charter took a different form. The New Haven County Society was the only one formally organized. It was this Society that had the committee of correspondence with foreign medical authorities and it was the Society that had published the famous "Cases and Observations." None of the other counties were organized in any substantial fashion, and their participation in the charter campaign had been carried on through somewhat loosely constituted local committees.

Because of this prestige and prominence it was thought that the New Haven County Society itself would have greater success in obtaining legislative recognition than the somewhat nebulous state organization. Therefore a petition for the incorporation of the Medical Society of New Haven County was filed in January 1791. To give importance to this petition and weight to the appeal, physicians from outside of New Haven County were elected to membership in the County Society. Among these were Nathaniel Perry of Woodbury, James Potter of New Fairfield, Amos Mead of Greenwich, Samuel Mather of Lyme, Joseph Trowbridge of Danbury, and James Clarke of Stratford. In April 1791 Eneas Munson and John Spaulding, both of New Haven, were chosen "a committee to engage an attorney to attend the petition and get it through the Assembly." This may have been the first legislative lobby in Connecticut; it was surely the first medical lobby in the Connecticut legislature. The New Haven County petition expressed appropriate humility and modesty. It said that the petitioners "do not presume to ask for any powers, privileges, exemptions or immunities, but humbly pray that your Honors will take our case into your wise consideration, and decree that your petitioners shall be formed into a body corporate and politic by the name of the Medical Society of New Haven County, for

the purpose of collecting and preserving a collection of useful papers relative to the practice of medicine." This petition was granted in the Lower House, but the Upper House according to its habit referred it for further consideration at the October session of 1791.

Events were moving rapidly, and the New Haven medical politicians were crowding every advantage. Early in October of 1791, before the convening of the General Assembly, the New Haven County Medical Society "voted that Messrs. Eneas Munson, Jared Potter, Levi Ives be a committee to revise and make such alterations in the bill now before the Honorable General Assembly, and take such measures to pursue, to effect, and expend such moneys as they shall think necessary."

Exactly what happened in October 1791 is not clear. There are Society records that give the impression that the New Haven County Society charter was in fact granted. The official records of the State of Connecticut fail to corroborate this implication. The campaign was, however, nearing a successful conclusion. The determination of the New Haven physicians, the publication of the "Cases and Observations" that had received wide acclaim, the "attorney" who had been retained to steer the measure, and the "moneys" that had been placed at the disposal of Eneas Munson and his two associates, were not without effect.

In January 1792 the County committees of correspondence were solicited to send a delegation to Hartford in the following May to meet at the house of Landlord Bull opposite the Court House. The legislature would be in session at that time, and the determined charter seekers were making ready for a last assault upon the Connecticut statesmen.

The bill that was being presented was free from the objectionable provisions of the rejected charter of 1787. It gave no authority to impose any fines for misbehavior. It did not give the Society the privilege to tax its members; this was provided in an early amendment. It did give the authority to appoint examining committees to issue licenses to those found qualified to practice physic and surgery, and to confer honorary degrees in medicine, and to hold property not exceeding \$16,667. The whole was a calm and peaceful request centering attention upon the improvement of the quality of medical education and service and making no implication whatever that could be construed to mean the formation of an exclusive, self-protective guild. The incorporators were James Potter, Fairfield; Leverett Hubbard, New Haven; Charles Phelps, New London; Joshua Porter, Litchfield; Amos Mead, Greenwich; Charles Mather, Hartford; Josiah Hart, Hartford; Eliakim Fish, Hartford; Samuel Flagg, Hartford; Eneas Munson, New Haven; Jared Potter, New Haven; John Lester, Fairfield; David Rogers, Fairfield; Philip Turner, New London; Elisha Perkins, Windham; Isaac Knight, Windham; Daniel Sheldon, Litchfield; Phineas Miller, Hartford; James Schovill, Fairfield; Samuel Woodward, Litchfield; Ichabod Warner, Tolland; Jeremiah West, Tolland; David Sutton, Tolland; Elihu Tudor, Hartford; Timothy Rogers, Litchfield; Lemuel Hopkins, Hartford; Joseph Baker, Windham; John Watrous, New London; Seth Bird, Litchfield; Minor Grant, Tolland;

Simeon Wolcott, New London; John Osborn, Middlesex; Asa Hamilton, Tolland; Theophilus Rogers, New London; Philemon Tracy, New London; Mason Cogswell, Hartford; Thaddeus Betts, Fairfield; Thomas Coit, New London; Joshua Downer, New London; Elnathan Beach, New Haven; John Turner, New London; John Spaulding, New London; Levi Ives, New Haven; James Clark, Fairfield; Albigence Waldo, Windham; John Clark, Windham; Elisha Lord, Windham. The medical convention of 1792 met in Hartford while the legislature was in session in accordance with the notice that had been distributed in January; and after what appears to have been a brief and quiet discussion, the Honorable General Assembly of the State of Connecticut passed an act of incorporation of the Connecticut Medical Society in May, 1792. It is believed to be the first private charter granted by the State of Connecticut.

In July members of the New Haven County Medical Society met and congratulated themselves upon the memorable work that had been done and made arrangements for the first meeting of the Connecticut State Medical Society, which was to be held in Middletown on October 9, 1792. The Society did meet for organization on that date, Doctor Leverett Hubbard was chosen president, Eneas Munson, vice-president, and Doctor Jared Potter the secretary, and the Connecticut Medical Society was launched on its honorable and productive course now in its 150th year.

CONNECTICUT STATE MEDICAL JOURNAL

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EDITORIALS

Doctors and the Law

Doctors often have a hard time understanding the intricacies and circumlocution of the law and it is not made much clearer by Professor Hamilton's discussion of the Government's case against organized medicine. It is not Mr. Hamilton's fault, he knows what he is talking about and his exposition is candid.

The *Journal* is pleased to have the opportunity to publish Mr. Hamilton's discussion. Many will not agree with what he has to say but the objections will be more emotional than logical. No good or bad thing will be decided by this case and Mr. Hamilton does not make it out to be that way. The courts in their devious and ponderous ways are again only laying down rules to determine legal rights and duties.

Peptic Ulcer Today

The medical and surgical treatment of peptic ulcer continues to undergo periodic changes. Back of these repeated changes is probably our lack of knowledge of the specific cause of the disease.

Many men can recall the use of silver salts in this condition, the premise being to stimulate healing of the ulcer. This has long been discarded. All know of the use of sodium bicarbonate alone, in an attempt to neutralize the acidity. The chemistry of this is now known to swing over to the acid side. Some are familiar with the use of foreign proteins and emetine and histidine preparations. In general these are not accepted. The council recently accepted aluminum hydroxide, the preparation commonly called amphojel. In accepting it, the council has insisted upon the name aluminum hydroxide gel. The so called Sippy regime has had and continues to have the largest following. This regime or one of its many modifications is probably the accepted method of managing the disease.

The surgical approach has gone through similar changes. Pyloroplasty, gastroenterostomy, excision of the ulcer have all had their proponents. At present the surgical procedure of choice seems to be subtotal gastrectomy. On physiological and pathological standards this procedure seems sound.

In an article in this issue of the journal, Sara M. Jordan outlines the problems confronting one in the

diagnosis and proper management of the condition. She pays particular attention to the danger of superimposed malignancy in recurring ulcers, the possibility of mistaking early malignancy for ulcer and the difficulties associated with the diagnosis of ulcer on the posterior wall. Doctor Jordan's advice, as one would expect from her wide experience, is excellent.

At the present time, there are some men who doubt that this condition can be cured medically or surgically. Fortunately these are in the minority. It may be safely said that the last word on peptic ulcer has not been uttered. This is as it should be. Medicine will not be satisfied until a cure is established. Until then medicine will keep changing in its endeavor to control this disease even though these changes be called revolutionary.

A Word of Caution

Long before the defense program was necessary there had been a steadily increasing program of activity for Americans, young and old. The days have never been sufficiently long to crowd in all that ambitious individuals and organizations encouraged. Each year the goal has to be higher, better, and record breaking. In business, pleasure, and social programs we race and supersaturate ourselves and our undertakings. Meetings, this job and that, rob us of our evenings, Sundays, and spare moments for quiet, reflection, and companionship with family and friends, which should be part of everyone's life. Long hours are spent, there is an increasing burden of responsibilities without sufficient control of what we do. Tension is evident in every walk of life, from the school child to the elderly person.

What is the result? Simple pleasures are going, people are tired, irritable, worried, sleeping restlessly, and in too many cases collapsing under the effort. Some of the breakdowns take long periods to mend, are costly, and in certain instances lead to or hasten fatalities, especially in the degenerative diseases. Each individual can do only so much, and if he or she accepts beyond a natural capacity, the general level of accomplishment becomes mediocre. Each one of us should look at himself critically, and eliminate unnecessary activities in order to provide more time for the national emergency, and to guard against becoming engulfed in this mad turmoil of fast and dissipated living.

Who Cares About the Mental Patient?

Because Connecticut is the home office of the insurance business of the country, we might reasonably expect its citizens to have a superior knowledge of the value of insurance as a factor in their daily lives.

Because Connecticut is the home of the Mental Hygiene movement—sponsored by Clifford Beers, a Yale man who is still its leading spirit—we might suppose that our citizens, and especially those of us interested in health, would be more alert than many others to the tremendous importance of the prophylaxis of mental disease.

We might conclude our syllogism with the statement that Connecticut is awake to the crying need of protecting its citizens against the incidence of preventable mental disorders. But is this conclusion justified? No doubt our psychiatrists as a group are aware of how much could be done were it not for public and professional inertia but are you, the internist, or you, the family doctor, acquainted with the startling national statistics? (a) 1 child in 20 destined for some period of institutional care. (b) More than 50% of first admissions to State Hospitals have never seen a psychiatrist. (c) Once there, the patient may have to share the psychiatrist's attention with hundreds of other patients. (d) Once there, his chance of lasting cure is not better than 50-50. (e) \$210,000,000 yearly spent on treatment; about \$5,000,000 on prevention in the form of mental hygiene clinics. (f) 58% of all hospital beds in this country are occupied by mental cases. (g) Roughly, one half of your private practise includes attention to mental or emotional problems. (h) Only a little over 1% of the country's physicians are psychiatrists. (i) More than half of these specialists are employed by institutions. (j) Mental disease costs the country \$777,000,000 per year. (k) Neuro-psychiatric difficulties rank fifth in the list of reasons for rejection of Selectees.

If you are the family doctor, this is primarily your problem. You are the first to note the symptoms; the first to interpret them to the family; the first to be asked the course to pursue. A surprisingly large number of these patients need only a kindly, sympathetic auditor, a bit of reassurance, some common sense advice. A druggist's prescription is a poor substitute for these.

Even in the more serious cases, as a leader in community attitudes, you should be prepared to

explain to the relatives the character of the problem, the means available for its management and to emphasize the humane character of modern therapy. Get acquainted with your local Mental Hygiene Clinic if one exists; if not, help establish one. Visit the nearest State Hospital, note the character of its work and hear its Director say, "Half of these patients could have been cured at home or their illnesses prevented if some competent physician had become sufficiently interested soon enough." "Too little and too late" is a poor slogan in peace or war."

The Medical Student in the Draft

Considerable editorial comment has appeared reprimanding the medical student for not showing more patriotism by applying for a commission in the Army. He has been termed a slacker and a draft dodger and calumny in plenty has been heaped upon his head. True, he is in danger of being drafted but still he does not enlist. In common with the group of physicians but recently entered upon their life work he is defended by the Editor of the *Journal of the South Carolina Medical Association*.^{*} The Southern editor believes that this group of young men do not feel that the Army needs them just now. He expresses the opinion that they themselves do not believe young physicians need the same amount of training for military service as do the draftees and that by remaining at home they are serving the public in their present location.

At the Secretaries Conference in Chicago (see page 915) it was made very clear that the arrangement whereby medical students are at present exempted from the Selective Service Act is by a gentleman's agreement only and may be terminated at the will of either or both the Surgeon General of the Army and the Surgeon General of the Navy. The medical student during his first two years, if scholastically satisfactory, is allowed to continue his studies. During his last two years and during the first year of internship he is expected to enlist in the Medical Administrative Corps as a Second Lieutenant and as such will not be drafted. At the end of one year of internship he is obligated, by virtue of the fact that he has been immune to the draft, to apply for a commission in the Medical Corps, U. S. Army or U. S. Navy. He may not be acceptable but the obligation to apply for a commission nevertheless remains.

The results have not fulfilled the expectations. We find many third and fourth year medical students and first year interns still waiting in the hope that they will not be expected to do anything but what they may have originally planned. The fault does not rest entirely with the student. In many medical schools information has not reached the student advising him as to his proper course. The faculty and administration of some medical schools have not been too coöperative. Doctor Abell, Chairman of the Committee on Medical Preparedness of the A. M. A., warns us that if medical students do not show their patriotism the Selective Service Act still holds and exemption, not being written in the law, may at any time be rescinded.

There should be no question of a prompt and wise decision by every medical student, at least in Connecticut, once he is properly informed.

The New Superintendent at Mansfield

On October 1, 1941, Doctor Neil A. Dayton assumed his duties as superintendent of the Mansfield State Training School and Hospital at Mansfield Depot, Connecticut. Doctor Dayton comes to this State from our neighbor, Massachusetts, where his record has been an enviable one. At the close of World War I Doctor Dayton entered the Massachusetts State Psychiatric service as Assistant Physician, Westboro State Hospital. Two years later he became Senior Physician at the same institution, only to accept a new position in 1922 as Assistant Superintendent of the Wrentham State School. After serving four years at the Wrentham institution, Doctor Dayton was appointed Assistant to the Commission of the Department of Mental Diseases and Director of the Division of Mental Deficiency. In addition to these last two State appointments he was made Director of the Rockefeller Research Project in Mental Diseases and Mental Defect in 1928, a member of the White House Conference on Child Health and Protection in 1930, and a member of the White House Conference on Children in Democracy in 1939. For the past eleven years Doctor Dayton has been an Instructor in Psychiatry at Tufts Medical School.

Doctor Dayton received his medical degree at Ohio State University and served internships in Huron Road Hospital, Cleveland, and in Metropolitan Hospital, New York City. In World War I he saw service overseas, attached to the British Army, and was awarded the Military Cross for dis-

^{*}Editorial, J. So. Car. Med. Assoc., Nov. 1941.

tinguished service in France. A member of many psychiatric organizations, Doctor Dayton has served the American Association on Mental Deficiency as vice-president, then as president and at present is secretary-treasurer.

As a writer Doctor Dayton's contributions to psychiatric literature during the past eighteen years have been manifold and valued. In particular, his statistical summaries have added important data in the field of mental deficiency.

As Connecticut physicians we welcome Doctor Dayton to our State. What is again Massachusetts' loss is Connecticut's gain.

The Section on General Medicine

In the resolution that the Michigan State Medical Society presented to the House of Delegates of the American Medical Association at the Cleveland session it said: "The general practitioner is the main bulwark against the clamor of public opinion for socialized medicine. The practitioner is loved, respected, and revered for his sacrifice and unselfish service. He is concerned with the patient's domestic trouble, he gives council and comfort. Unlike the specialists, is not so mercenary as to allow financial arrangements to take precedence over care of the needy, he is not conveniently absent for night calls, and hesitates not to leave his dinner for emergencies. So, we hear the crying need for the general practitioner. Much praise and reverence is given him. But, until recently, no attempt was made to preserve him. We seek to ameliorate his status in the profession."

The members of The Connecticut State Medical Society who are interested in the practice of general medicine, pursuing the honored course of the "family doctor," have for some time contemplated the organization of a Section on General Medicine in the Society. Some of the preliminary plans for the Section were made during the Annual Meeting of the Society in Bridgeport in May of this year. A committee was appointed to consider the type of organization, its by-laws, and its objectives. That committee is now ready to report and an Organization Meeting of the Section will be held at the New Haven Medical Association on December 18.

One of the purposes of the Section is to present to its members practical and useful procedures that may be applied in their practice. After the organi-

zation of the Section has been completed at the meeting on December 18 Harry E. Bacon of Philadelphia has been invited to present a discussion of "Office Procedure in Proctology." Those who heard Doctor Bacon at a recent Clinical Congress will recall his valuable and practical approach to the simpler procedures of proctology that may be used by the physician in his office.

There are many subjects of interest and importance to the practitioner of general medicine and the future interests of the Section will include consideration of the status of the general practitioner on hospitals staffs, medical legislation and administration that affect him in his practice, and the frequent role he has to play in legal testimony.

Dinner will precede the meeting on the 18th and all those wishing to attend should inform Doctor Hermann S. Cutler, 425 Forbes Avenue, New Haven, who is serving as the temporary chairman for the Section. A remittance of \$1.00 should accompany an acceptance. Dinner at 6:30, the meeting promptly at 8:00 o'clock, the New Haven Medical Association, 364 Whitney Avenue, at the corner of Lawrence Street.

Chairman of the Council Honored

At the recent annual meeting of the Medical Society of Virginia held at Virginia Beach, James R. Miller, Chairman of our Council, addressed the gathering on Office Problems in Gynecology. The Virginia Obstetrical and Gynecological Society honored Doctor Miller by electing him to honorary membership.

Hawaii Medical Journal, Vol. I, Number 1

We are privileged to welcome the new bimonthly journal published by the Hawaii Territorial Medical Society in Honolulu. The Journal supplants the former bulletin. This first number contains good scientific articles as well as much informative data pertaining to medicine in Hawaii. The cover contains a line drawing from a photograph of the main entrance of the building housing the Association's office. In this design appear the Aesculapian staff and serpent. The general arrangement of the cover seems to have been inspired by the cover design of the Pennsylvania Medical Journal.

Greetings to our Island friends!

FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

258 CHURCH STREET

NEW HAVEN

SPECIAL MEETING, HOUSE OF DELEGATES

December 10, 1941

In accordance with Section II, Chapter 4 of the By-Laws, the Council of the Connecticut State Medical Society has directed the calling of a special meeting of the House of Delegates of the Society to be held at 1:30 P. M. on Wednesday, December 10, 1941, at the New Haven Medical Association, 364 Whitney Avenue, New Haven.

The agenda for this meeting is given herewith and no matters of business not included may properly come before the meeting.

Delegates who find it impossible to attend this meeting should notify the Secretary of their county association at once in order that an alternate may be designated.

MEMBERS OF THE HOUSE OF DELEGATES WILL BE GUESTS OF THE SOCIETY FOR LUNCH AT 12:30 PRECEDING THE MEETING.

James Douglas Gold, M.D., *President.*

1. THE BUDGET FOR 1942

The Council recommends to the House of Delegates the adoption of the following budget and assessment of dues of \$15.00 per member for the year 1942.

Society's Office

Personal Service.....	\$11,900.00	
Rent	1,020.00	
Postage	1,200.00	14,120.00 increased
		\$40.00
<i>Journal</i>	3,600.00	unchanged

Treasurer's Contingent Account

Miscellaneous and contingent expense	\$2,000.00	
Committee on Public Relations	300.00	
Committee on Prepaid Medical Service	300.00	
Committee on Medical Preparedness	500.00	
Council	150.00	
Chairman of Council	300.00	
A. M. A. Delegates.....	200.00	
Secretary's Annuity	1,000.00	
Sesquicentennial Cele- bration	2,500.00	7,250.00
Total		\$24,970.00

2. ASSOCIATE MEMBERS

In accordance with Chapter II, Section 2, the Council recommends to the House of Delegates the election of the following Associate Members of the Society:

HAROLD S. BURR, PH.B. Yale 1911, PH.D. Yale 1915
E. K. Hunt Prof. of Anatomy, Yale University
School of Medicine and Chief of Section on
Neuro Anatomy.

JOHN F. FULTON, S.B. Harvard 1921, B.A. Oxford
1923, M.A. Oxford 1925, PH.D. Oxford 1925, M.D.
Harvard 1927, D.S.C. Oxford 1941, Sterling Prof.
of Physiology, Yale University School of Medi-
cine.

HOWARD W. HAGGARD, PH.B. Yale 1914, M.D. Yale
1917, Prof. Applied Physiology, Yale Univer-
sity School of Graduate Studies.

IRA V. HISCOCK, B.A. Wesleyan 1914, M.A. Wes-
leyan 1916, C.P.H. Yale 1921, M.A. Yale 1931,
S.C.D. Wesleyan, 1939, Prof. Public Health, Yale
University School of Medicine.

CYRIL N. H. LONG, B.S. University of Manchester,
England, 1921, M.S. Manchester 1923, M.D., C.M.
McGill 1928, D.S.C. Manchester 1932, M.A. Yale
1936, Sterling Prof. Physiological Chemistry,
Yale University School of Medicine.

FRIEND LEE MICKLE, A.B. Allegheny College 1911,
M.S. University of Illinois 1917, S.C.D. Allegheny

1936, Director of Bureau of Laboratories, Conn. State Department of Health.

WILLIAM C. WELLING, B.A. Yale 1909, Harvard School of Public Health 1924-1925, Director Bureau of Vital Statistics, Conn. State Department of Health.

3. CUSTODIAN OF JOURNAL FUNDS

The Council recommends to the House of Delegates the rescinding of Paragraph 4 of Resolution 6 passed by the House of Delegates at its second session on May 20, 1937, which reads as follows:

"The entire editorial and advertising policy of the Journal of The Connecticut State Medical Society shall be vested in the above-mentioned Editorial Board of which the Secretary on Scientific Work, serving as editor-in-chief of the Journal, shall be Chairman. This Board shall elect from among its number, but not the Secretary on Scientific Work, one member who shall be designated as the Custodian of the Journal Funds. He shall receive and disburse all monies properly belonging to the Journal, and his account shall be audited each year just preceding the Annual Meeting of the Society by the Society's Auditing Committee. This Custodian shall receive an honorarium of \$100.00 per year, to be paid from the Funds of the Journal."

And substitute therefor the following:

The editorial and advertising policy of the Connecticut State Medical Journal shall be vested in the Editorial Board, one member of which shall be named the Editor-in-Chief who shall serve as Chairman. This Board shall elect from among its number, but not the Editor-in-Chief, one member who shall be designated as the Custodian of the Journal funds. He shall be the Custodian and disbursing agent of all funds allocated to the Journal for its operation. His account shall be subject to the periodical and general audit applied to the funds of the Society. This Custodian shall receive an honorarium of \$100.00 a year to be paid from the funds allocated to the Journal.

4. PRINCIPLES AND RECOMMENDATIONS FORMULATED BY JOINT CONFERENCE COMMITTEE OF CONNECTICUT PHARMACEUTICAL ASSOCIATION AND CONNECTICUT STATE MEDICAL SOCIETY

The Council recommends to the House of Delegates the adoption of the principles and recommendations formulated by the Joint Conference Committee of Connecticut Pharmaceutical Association and Connecticut State Medical Society.

THE HOUSE OF DELEGATES

The President of the Society
The President-Elect of the Society
The Executive Secretary of the Society
The Treasurer of the Society

Councilors

S. F. Mullins, <i>Fairfield</i>	T. P. Murdock, <i>New Haven</i>
A. B. Landry, <i>Hartford</i>	G. H. Gildersleeve, <i>New London</i>
C. H. Turkington, <i>Litchfield</i>	C. T. LaMoore, <i>Tolland</i>
A. N. Sweet, <i>Middlesex</i>	R. C. Paine, <i>Windham</i>

Elected Delegates

FAIRFIELD COUNTY

D. C. Brown, <i>Danbury</i>	J. P. McManus, <i>Bridgeport</i>
E. J. Finn, <i>Shelton</i>	F. A. Read, <i>Old Greenwich</i>
J. G. Frothingham, <i>New Canaan</i>	U. S. Reich, <i>Bridgeport</i>
R. A. Gandy, <i>Stamford</i>	O. L. Stringfield, <i>Stamford</i>
D. B. Hardenbergh, <i>Bridgeport</i>	W. A. Sunderland, <i>Danbury</i>
D. F. Keegan, <i>Bridgeport</i>	F. J. Wales, <i>Monroe</i>
Alternate J. G. Booe, <i>Bridgeport</i>	

HARTFORD COUNTY

L. Antupit, <i>Hartford</i>	J. R. Miller, <i>Hartford</i>
F. S. Bird, <i>Bristol</i>	F. I. Oberg, <i>Hartford</i>
T. F. Brewer, <i>Hartford</i>	A. Kilbourn, <i>Hartford</i>
C. C. Burlingame, <i>Hartford</i>	C. T. Schechtman, <i>New Britain</i>
B. B. Earle, <i>Glastonbury</i>	F. J. Turbert, <i>Hartford</i>
L. H. Frost, <i>Plainville</i>	S. B. Weld, <i>Hartford</i>
W. R. Hanrahan, <i>Bristol</i>	T. W. Worthen, <i>Hartford</i>
W. Levy, <i>Suffield</i>	E. R. Zaglio, <i>Manchester</i>

LITCHFIELD COUNTY

F. A. Sutherland, <i>Torrington</i>	W. B. Walker, <i>Cornwall</i>
W. E. Wight, <i>Thomaston</i>	

MIDDLESEX COUNTY

J. W. Fisher, <i>Middletown</i>	W. N. Nelson, <i>Cromwell</i>
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NEW HAVEN COUNTY

P. J. Brennan, <i>Waterbury</i>	J. I. Linde, <i>New Haven</i>
T. S. Evans, <i>New Haven</i>	R. F. McDonnell, <i>New Haven</i>
W. J. H. Fischer, <i>Milford</i>	L. H. Nahum, <i>New Haven</i>
C. B. Gibson, <i>Meriden</i>	R. W. Nichols, <i>New Haven</i>
R. J. Hinchey, <i>Waterbury</i>	J. H. Root, <i>Waterbury</i>
A. J. Jackson, <i>Waterbury</i>	M. S. Shea, <i>New Haven</i>
M. J. Lawlor, <i>Waterbury</i>	F. N. Sperry, <i>New Haven</i>
M. J. Strauss, <i>New Haven</i>	

Alternates

B. R. Harris, <i>New Haven</i>	E. J. Godfrey, <i>Waterbury</i>
W. E. Hall, <i>Meriden</i>	G. Blumer, <i>New Haven</i>
W. I. Russell, <i>New Haven</i>	

NEW LONDON COUNTY

E. L. Douglass, <i>Groton</i>	A. C. Freeman, <i>Norwich</i>
T. Soltz, <i>New London</i>	W. H. Wiedman, <i>Norwich</i>

TOLLAND COUNTY

W. H. Higgins, <i>South Coventry</i>

WINDHAM COUNTY

R. L. Gilman, <i>Storrs</i>	W. M. Shepard, <i>Putnam</i>
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Members Elected at Semi-Annual Meetings in October

HARTFORD COUNTY ASSOCIATION

- John W. Bick, Hartford
Tulane University School of Medicine, 1937
- Aaron Bobrow, Hartford
University of Bern, 1936
- Kenneth F. Brandon, Hartford
University of Toronto Faculty of Medicine, 1934
- James R. Cullen, Hartford
Georgetown University School of Medicine, 1936
- Edward Dorian, New Britain
University of Maryland, 1937
- George D. Dorian, New Britain
Hahnemann Medical College 1939
- Lucille R. Farquhar, Avon
Yale University School of Medicine, 1937
- Thomas M. Feeney, Hartford
Boston University School of Medicine, 1936
- Roger H. Fuller, Simsbury
Tufts Medical School, 1938
- Forrest D. Gibson, Hartford
Syracuse University College of Medicine, 1935
- Max Hayman, Hartford
University of Manitoba Faculty of Medicine, 1935
- Derick A. January, Hartford
Yale University School of Medicine, 1934
- Paul Johnson, West Hartford
Tufts Medical School, 1932
- Samuel S. Katzman, Hartford
Jefferson Medical College, 1921
- John W. Kinley, Hartford
McGill University Faculty of Medicine, 1931
- William J. Kucewicz, Thompsonville
St. Louis University School of Medicine, 1936
- W. Holbrook Lowell, Jr., Hartford
Harvard Medical School, 1937
- Harry L. MacKinnon, Hartford
University of Cincinnati College of Medicine, 1939
- Jacob A. Segal, Manchester
Tufts Medical School, 1928
- John C. Shull, West Hartford
Harvard Medical School, 1936
- James J. Sponzo, Hartford
Tufts Medical School, 1938
- Arthur B. Sullivan, West Hartford
Yale University School of Medicine, 1938
- Francis W. Trapp, New Britain
Georgetown University School of Medicine, 1936
- William M. Wiepert, Avon
Yale University School of Medicine, 1937
- Morris S. Wineck, Hartford
University of Vermont College of Medicine, 1915

NEW HAVEN COUNTY ASSOCIATION

- John C. Allen, New Haven
Hahnemann Medical College, 1939
- Philip A. Bearg, New Haven
Yale University School of Medicine, 1937
- Charles M. D'Alessio, Derby
University of Maryland, 1937
- Sidney Feyder, New Haven
University of Rochester, 1936
- Russell V. Fuldner, New Haven
Columbia University, New York, 1933
- Lena Halpern, New Haven
Yale University School of Medicine, 1935
- Peter Lehdorff, East Haven
University of Vienna, 1937
- Henry Merriman, New Haven
Columbia University, New York, 1936
- William L. Peltz, New Haven
Harvard Medical School, 1936
- Mayo R. Purple, New Haven
Yale University School of Medicine, 1937
- Alfred E. Reichenbach, Waterbury
Tufts Medical School, 1938
- Oscar Roth, New Haven
University of Vienna, 1937
- Jacob A. Saltzman, Waterbury
New York Medical College, 1933
- Joseph Sklaver, Waterbury
University of Michigan, 1937
- Andrew Vollero, New Haven
Tufts Medical School, 1930

TRANSFERS

- Clarence H. Cole, Waterbury
Yale University School of Medicine, 1932
- Samuel Nesbitt, New Haven
Harvard Medical School, 1935

Committees Meet

The Program Committee of the 1942 Clinical Congress, under the chairmanship of Doctor Louis H. Nahum, had its preliminary meeting on November 10.

The Committee on Prepaid Medical Service, under the chairmanship of Doctor Oliver L. Stringfield, met in conference with Mr. Robert Parnall of the Connecticut Plan for Hospital Care on November 19.

The Sesquicentennial Committee and many of the sub-committees have met frequently. Members having historical memorabilia to place in the historical exhibit during the celebration in Middletown June 1942 are requested to communicate with Doctor Arthur H. Jackson, Washington.

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ANNUAL SECRETARIES CONFERENCE AT CHICAGO

Disposition of Medical Students and Re-examination of Draftees Explained

The Annual Conference of Secretaries and Journal Editors of the various State Medical Societies held at A. M. A. headquarters in Chicago, November 14 and 15, clarified two problems for the medical profession.

Medical students may become exempt from Selective Service in their third and fourth years by enrolling in Medical Administrative Corps as Second Lieutenants. This will permit them one year of internship. They are then eligible for commissions as First Lieutenants, U. S. Army, Medical Corps.

Between 200,000 and 300,000 draftees deferred by local Selective Service boards face early re-examination and possible induction into the Army under new physical examination plans.

Classification and Disposition of Medical Students

In his address the first morning of the Conference, General McAfee, U. S. Army, stated that medical students in their junior and senior years and during their first year of internship might apply for commissions as Second Lieutenants in the Medical Administrative Corps, U. S. Army, and Lieutenants Junior Grade, U. S. Navy Reserve, and thus be exempt from the draft. The following day Irvin Abell, Chairman of the Committee on Medical Preparedness of the A. M. A. and Chairman of the Health and Medical Committee of the Federal Security Agency, added that an attempt had been made to have first and second year medical students eligible for M. A. C. commissions. This was unsuccessful. Medical students during their first two years, however, if scholastically satisfactory are exempt from the draft by agreement with the Surgeon General of the Army and the Surgeon General of the Navy. After graduation from medical school, while still enrolled in M. A. C., the young doctor may serve one year internship in either an Army, Navy, or civilian hospital. At the end of this period he may be offered a commission as First Lieutenant, U. S. Army Medical Corps, or as Lieutenant Senior Grade, U. S. Navy Medical Corps. Obtaining such a commission depends on proper physical and professional qualifications. There is no longer to be any Reserve Corps.

The exemption from the draft thus afforded medical students, not being written in the law but being merely a gentlemen's agreement, may be rescinded at any time and the Selective Service Act apply to all alike, should the embryo doctors not apply for M. A. C. commissions in sufficient numbers. It is the opinion of General McAfee that medi-

cal students commissioned in the M. A. C. have assumed an obligation and are duty bound to apply, at the end of one year internship, for commissions in the Medical Corps. Doctor Fishbein informs us that some medical schools have about 95% of the student body enrolled in the M. A. C. while other schools have only about 5%. He believes this is due to the attitude of the faculty toward the government and the present emergency and that the question of morale among the younger generation of physicians goes directly back to the medical schools. Discussion of this situation brought out the fact that in many instances the seeming lack of patriotism on the part of medical students was due to the fact that they had not been properly informed, as well as to the uncertainty of their position in relation to the draft.

Physician's Role in Selective Service System

Brigadier General Lewis B. Hershey, Director of the Selective Service System, presented the most lucid and informative discussion of the entire Conference. He called attention to the changes which have been made in the draftee examinations in an endeavor to avoid duplication of the physician's work. The Army, according to General Hershey, is now better organized to carry the responsibility of the examinations and to execute the final physical examination as near as possible to the place where the draftee lives. The medical examiner's work is to be complementary and not to duplicate the induction examination. Under the new regulations the local board is asked to reject draftees where no question exists as to their lack of proper physical requirements, otherwise they will send whatever data they may obtain concerning draftees along with the individuals to the Army induction center for the decision as to eligibility.

General Hershey paid the physicians a gracious complement when he stated that the local boards are giving the nation in gratuitous service something which could not be bought because of its magnitude. He believes the local board physicians should be relieved of much of their clerical work and should be able to serve more in an advisory capacity. Under the new examination regulations it is hoped this will be true.

Local board examiners will be asked to comb over between 200,000 and 300,000 draftees who have been rejected because of border line conditions in order to find possible candidates for rehabilitation to make them fit for service. The rejection rate has been so high that if the Army requires more personnel than at present it will be necessary to find soldiers among those previously rejected. General Hershey wants to make more ten tooth rejects into twelve tooth soldiers. Said General Hershey, "We had 17,500,000 men available and it looked like a lot of material. But now we haven't enough men to fill the ranks if there is any fresh call. We must recheck our rejections. Frankly, I am worried by the number of men deferred for dependents. . . . I am worried about the number of N. P. rejections. In one state forty per cent of the rejections were of this kind, made because medical examiners thought boys might develop some degree of mental disorder if compelled to join the Army."

Federal Security Agency

Watson Miller, Assistant Administrator of the Federal Security Agency, informed the Conference that it is the object of the Federal Government to man the facilities for medical care in rapidly growing defense work areas and thus protect the physician. He explained the new Procurement and Assignment Service which is endeavoring to supply medical and dental care where the need exists. It is the hope of this Service that the demands will be met by voluntary acceptance on the part of physicians, dentists, etc., even though these changes may not always appear to be opportunities but rather hardships to those affected. Hospital and health centers operated by local groups are being augmented in personnel by the Federal Security Agency in order to maintain the proper standards of medical care. The loss to industry from non occupational diseases was emphasized, about ninety per cent of the total. About two thirds of the industrial plants today do not have properly equipped and staffed medical departments. The need of prepayment plans

for medical care for the low income group was brought out. Many workers do not need to be hospitalized. *Labor and medicine together should devise some way to aid the worker in paying his medical bills.*

Procurement and Assignment Service

Major Seelye, Executive Officer of the newly formed Procurement and Assignment Service, explained very clearly the function of this organization. It is divided into two groups, one devoted entirely to research in such fields of medicine as industrial health, aviation medicine, tropical medicine, and chemotherapy; the other group serves in an advisory capacity to the Surgeon General and represents such key factors as nutrition, hospitals, medical education, public health, and women physicians. The budget for this Procurement and Assignment Service was assured by President Roosevelt in October of this year.

Doctor Irvin Abell appealed to the medical profession for whole hearted support of this new service. It is to be carried out on a voluntary basis to save time necessary for legislation, hoping that Congress will approve it later. *It has become necessary because of the shortage of medical personnel in all branches of defense.* The Army at present is short 1500 medical officers. All Federal agencies except the Navy are short medical officers. The Public Health Service is short. The Veterans Bureau is short 300 medical officers. Civil Service is short medical personnel. There is a shortage of nurses even though about twice as many are being graduated today as in 1916.

Industrial Health

Doctor C. M. Peterson, Secretary of the Council on Industrial Health of the A. M. A., ably presented the problems in this field. The Council on Industrial Health is developing (1) an educational program and (2) a clarification of the standards of medical care in industry. Properly qualified personnel for field employment has been supplied by the Council to obtain information on industrial health problems. Committees on Industrial Health have been organized in the various State Medical Societies and are now appearing in each medical specialty of the A. M. A. Medical schools and medical societies have not been interested in improving graduate study in industrial health. It is the opinion of Doctor Peterson that interest in industrial health will not wane after the present emergency is over. *The small*

industrial plants need guidance in providing adequate health and medical control against hazards. Labor needs guidance from proper medical sources for its problems.

Medical Aspects of Civilian Defense

Doctor George Baehr, Chief Medical Officer of the Office of Civilian Defense (O. C. D.), presented the threefold aims of this organization: (1) the protection of lives; (2) the protection of property; and (3) the preservation of morale. O. C. D. operates under the Office of Production Management. The Medical Division of the O. C. D. has developed plans so simple they may be adopted by all. They comprise (1) plans for emergency casualty services which include casualty stations and First Aid posts; (2) plans for the development of Volunteer Nurses Aids to meet the need created by the depletion of hospital personnel; and (3) plans for the training of the civilian population in First Aid.

Prepaid Medical Service and Hospitalization

The principles involved in prepaid medical service and group hospitalization plans were presented by the Editor-in-Chief of this JOURNAL. Doctor Peter Irving, Secretary of the Medical Society of the State of New York, related the experiences of his State in developing medical indemnity insurance plans. There are now nine organizations in New York State selling hospital insurance. The New York law permits the selling of prepaid medical care contracts and of hospitalization contracts but not by the same company. Two corporations, however, may issue a combined contract for hospital and for medical care. A new contract is now being sold by Community Medical Care, Inc. which proposes to provide within the single policy, in collaboration with a hospital insurance organization, both medical and hospital care for *ward patients*. There is no free choice of physician under this contract but the physicians serving on the wards will receive some compensation for the care of patients holding this contract.

The Editor-in-Chief of the *Connecticut Journal* appealed to the Conference for open mindedness in developing proper plans for prepayment medical and hospital care. He reminded his audience that

the experience of our forebears would be of little help in guiding us in this socially changing world. The care of the patient must come first and whether or not physicians will serve as salaried employees of a hospital, on full time in industrial plants, as part of clinics sponsored and guided by some of our leading surgeons, or in the individual practice of medicine in rural communities should make little difference. *If we do not find some means of affording good medical care within reach of the low income group, it will be found for us and not altogether to our own liking.*

Better Nursing for America

*Better Nursing for America** is a pamphlet just published by the Public Affairs Committee of the American Nurses' Association and presenting in a clear, brief, narrative form the reason for the Nation's urgent need for more nurses. It is based on data provided by the three national nursing organizations—The American Nurses' Association, The National League of Nursing Education, and the National Organization for Public Health Nursing. In addition to the 400,000 registered nurses at work in hospitals, homes, camps, schools and communities, the pamphlet points out that the national emergency and the increased public demand for health and medical service have created a need for some 30,000 more. The need is for well prepared nurses and even while a student the nurse makes an important contribution to the nurse power of the nation.

Sulfanilamide and Diet

Experimental work on mice at the National Institute of Health has shown wide variations in the therapeutic response to sulfanilamide by alterations in diet. Diets deficient in proteins have shown higher concentrations of sulfanilamide in the blood, this proving that the protein fraction is important in the inhibition of the action of sulfanilamide.

*Better Nursing for America may be ordered from the Nursing Information Bureau of the American Nurses' Association, 1790 Broadway, New York. Price 10 cents. Liberal discounts on quantity orders.

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THE CONNECTICUT HOSPITAL ASSOCIATION

WILMAR M. ALLEN, M.D., President
WILLIAM B. SWEENEY, Secretary

ANNA M. GRIFFIN, Vice-President
HELEN NIVISON, Treasurer

We hoped this month to present to our readers the organization set-up of the various smaller hospitals in the state and have been fortunate in securing the following facts from three institutions. The Editor feels that this information may be of some interest and help in the various hospitals of this group.

Bristol Hospital

Approximately a year ago, some of the leading spirits of the Bristol Hospital felt that a reorganization of the staff would be desirable. Material for help in making this change was obtained from a number of hospitals in the vicinity, emphasis being laid particularly on what would be most suitable and flexible for a hospital the size of ours.

The chief difference in the set-up from that prevailing heretofore lies in the fact that from now on the scientific work and everything pertaining thereto is directly in charge of a medical board. This board is composed of five members representing the surgical, medical and obstetrical staffs. The medical board was originally created by the Executive Committee but will now be elected annually—in January—from the attending staff. This group will then organize and elect a president of the board who will serve as president of the medical staff for the ensuing year, a chief of each service (medical, surgical and obstetrical), a chief of records and one other. All this is subject to the approval of the executive committee.

The chief of records appoints two other members from the staff to act with him as a record committee. This committee will inspect the Record Department at frequent intervals and it is their business to see that all histories are properly completed within the specified limit.

The chief of each service handles the minor problems that come up from day to day for adjustment but the major problems from any service or from any department in the hospital will automatically come before the medical board for action.

The board meets once a month, except in July

and August, to discuss the various problems facing the hospital, making recommendations for correction or giving suggestions to be taken up by the executive board at a later date. At the monthly staff meeting the medical board reports to the staff if anything has come up during the past month.

Every Saturday morning from 11:00 to 12:00 A.M. the staff has its clinical conference where interesting cases are discussed. The members of the staff, except consultants, are expected to attend monthly staff meetings and the weekly clinical conferences.

Griffin Hospital, Derby

DEPARTMENT OF NURSING

- 1 Superintendent of Nurses
- 2 Supervisors
- 2 Night Supervisors

MEDICAL AND SURGICAL FLOORS

- 3 Head Nurses
- 16 Staff Nurses
- 8 Nurses' Aides
- 3 Orderlies

OPERATING ROOMS

- 1 Supervisor
- 1 Assistant Supervisor
- 4 Scrub Nurses
- 2 Nurses' Aides
- 1 Orderly

OBSTETRICAL DEPARTMENT

- 1 Supervisor
- 1 Assistant Supervisor
- 2 Nursery Nurses
- 9 Staff Nurses (Average)
- 3 Nurses' Aides

LABORATORY

- 1 Part Time Pathologist
- 3 Technicians

GENERAL OFFICE AND RECORD

ROOM

- 7 Employees

X-RAY DEPARTMENT

- 1 Part Time Roentgenologist
- 2 Technicians

DIETARY DEPARTMENT

- 1 Dietitian
 - 1 Assistant Dietitian
 - 1 Chef
 - 2 Assistant Cooks
 - 3 Waitresses
 - 3 Maids
- (This include the general kitchen and special diet kitchen.)

ENGINEERING & MAINTENANCE

DEPARTMENTS

- 2 Repair Men
- 3 Firemen

HOUSEKEEPING DEPARTMENT

- 1 Housekeeper
- 3 Porters
- 12 Maids

LAUNDRY

- 5 Employees

STAFF ORGANIZATION

Divided into:

- Medical, Surgical and Pediatric
- Obstetrical
- E. E. N. & T.
- Anaesthesia
- Pathology
- X-ray
- Senior Staff and Assistants
- Consulting Staff
- Courtesy Staff

Our daily average cost for the last fiscal year was \$5.71.

The Windham Community Memorial
Hospital, Inc., Willimantic

The Windham Community Memorial Hospital, Inc., is a 91 bed general hospital located at Willimantic and serving a small industrial city and 15 adjacent rural towns with a population of approximately 35,000. The occupancy for the last fiscal year ending June 30th was 70% with 3,016 patients treated and 264 births. The census for every month of this fiscal year has been in excess of 82%. Our organization for administrative purposes is as follows:

A. ADMINISTRATION—5 persons

Supervision	Superintendent
Accounting	Admitting Clerk
Statistical	Accountant
Admitting	Secretary
Public Relations	Historian

B. NURSING

All graduate staff	1 Supervisor
(No training school)	2 Night Supervisor
Laboratory	3 Head Nurses
Radiology	19 General Duty Nurses
Physio-Therapy	4 Nurse Aids
	3 Technicians

C. DIETARY DEPARTMENT

Central Tray Service	1 Dietitian
Kitchen Staff	9 Kitchen Staff
Cafeteria	3 Cafeteria

D. HOUSEKEEPING DEPARTMENT

Room Maintenance	1 Housekeeper
Linen Control	6 Floor Maids
Nurses' Home	1 Janitor
	2 Nurses' Home Maids

E. LAUNDRY

Linen	1 Foreman
Uniforms	2 Workers
<i>Note:</i> All employees' uniforms are furnished and laundered by the hospital.	

F. MECHANICAL DEPARTMENT

Power	1 Engineer
Maintenance	1 Fireman
Ambulance	

CONFERENCES

A Departmental conference is held the first Monday of every month with the following representation: Superintendent, Supervisor of Nursing, Supervisor of Surgery, Supervisor of Obstetrics, Dietitian, Laboratory Technician, Therapy Technician, Radi-

ology Technician, Housekeeper, Engineer, Laundry Foreman. All interdepartmental problems are discussed and notices given of new procedures.

ADMINISTRATION CONFERENCE

This meeting is held every week and attended by the Superintendent, Admitting, Statistical, Accounting and Credit representatives.

NURSING CONFERENCE

Meets every Monday at noon and is attended by the Supervisor of Nursing, Supervisor of Surgery, Supervisor of Obstetrics, and Head Nurses.

PROFESSIONAL STAFF CONFERENCE

Meets weekly with Superintendent. Consists of Chiefs of Services, President of Medical Staff and Delegate-at-large from Staff. Problems concerning medical staff are discussed, review of new procedures, additions to drug list, etc., and report made to monthly medical staff meeting.

HOSPITAL DEPARTMENTS

For the purpose of accounting the Hospital is organized into 16 departments (see below). The figures are based on our last fiscal year ending June 30, 1941, and show the total cost of each department, including wages and also the proportionate cost of each department per patient day for the year. This record is also kept monthly and summarized for the year to date each month.

		COST	
DEPT NO.	DEPARTMENT	TOTAL ANNUAL EXPENDITURES	PER PATIENT DAY ANNUAL
400	Administration	\$11232.17	\$.54 9
410	Dietary	27006.66	1.32
420	Housekeeping	5507.39	.26 9
430	Laundry	3517.62	.17 2
440	Heat, Light, Power	9745.84	.47 7
450	Maintenance and Repairs	3631.01	.17 7
460	Maintenance of Grounds	776.23	.03 7
470	Motor Service	493.07	.02 4
490	Nursing Care	27934.87	1.36 6
500	Nurses Home	2914.60	.14 2
510	Pharmacy	3536.53	.17 3
520	Medical and Surgical Service	3825.44	.18 7
530	Medical Records and Library	1552.59	.07 5
540	Anesthesia Service	818.98	.04
550	Radiology Dep't	2648.19	.12 9
560	Laboratory Service	2398.16	.11 7
570	Physiotherapy Department	621.83	.03
		(9 months)	
Total expenditures		\$108161.18	\$5.29

Our Income for the same period is allocated as follows:

Private Rooms	\$17316.50
Semi-private Rooms	9841.25
Private Wards	5486.50
Public Wards	9596.13
Operating Room	5956.50
Delivery Room	2520.00
Emergency Room	669.25
Radiology	6539.19
Laboratory	5929.00
Anesthesia	1073.87
Special Nurses Board	1748.00
Drugs and Medicine	2045.18
Casts	910.00
Ambulance	1040.00
Telephone and Telegraph Services	188.98
Dressings	36.36
Meals Service	52.95
Physiotherapy	824.50
Name Bracelets	65.00
Bacteriology	604.00
Discounts	19.90
Bad Debts Recovered	528.58
Miscellaneous	1131.95
Basal Metabolism	130.00

\$104253.59

Less Accounts Rec. Allowances	\$ 468.87
Less Provision for Bad Debts	5831.69
Less Prepayment Discounts	334.45

6635.01

Total Operating Income	\$ 97618.58
Total Corporate Income	12056.80

Total Income	\$109675.38
Total Expenses	108161.18

Excess of Income over Expenses	\$ 1514.20
Gifts for Special Purposes	632.78

We operate with no endowment funds. We maintain our own Budget Fund organization of approximately 175 persons, all volunteers, and at the close of every fiscal year conduct our own budget campaign. Last year we raised \$12,507.00 in a one week's campaign with campaign expenses of approximately \$560.00. We have a large Woman's Auxiliary of over 600 members with sub-chapters in each of the fifteen Community Towns, all working on definite monthly schedules in sewing and dressings. In addition we have a Junior Auxiliary of 175 high school girls who work daily at the Hospital on a volunteer basis in teams of a captain and six workers. Some interesting statistics follow:

For the Year:

Full Pay Patients	25%
Part Pay Patients	57%
Town and State Patients	11%
Free Cases	7%

Income Analysis:

Operating Income	89 % of our total
Gifts	0.5% of our total
State and Town Aid	10 % of our total
All other Sources	0.5% of our total
Endowments	0.0% of our total

Division of the Operating Income (first item above):

Private and Semi-private Rooms	27%
Wards	46%
Operating, Delivery, Emergency	9%
X-ray Laboratory	12%
All Other Sources	6%

Department Expense Analysis:

Dietary	25% of total expenses
Nursing Care	26% of total expenses
Diagnostic	4% of total expenses
Administration	10% of total expenses
Housekeeping and Laundry	8% of total expenses
Heat, Light, Power	8% of total expenses
All Other Departments	19% of total expenses

Wages	57% of total expenses
Supplies and Service	43% of total expenses

Sources of Patients:

Residents of City	56%
Community Towns	33%
Non Residents	11%

One out of every 12 persons residing in our Hospital area was treated at our Hospital during the past year. This figure has been consistent for the past seven years.

Charlotte Hungerford Hospital

The total number of members enrolled in the Charlotte Hungerford Hospital Auxiliary according to report presented by Mrs. William A. Gleeson, Chairman of the Membership Committee, at a meeting held October 21, was given as 1711. This is by far the largest membership in the history of the organization, it is an increase of 600 over last year and exceeded the goal fixed at the beginning of the drive by over 200. At the meeting it was voted to buy dental instruments for the hospital, and to authorize the house furnishings committee to purchase curtains, slip covers and lamp shades and to reupholster some furniture. The president, Mrs. John H. Thompson, announced the appointment of the following committees for the ensuing year:

Hospital Supply—Mrs. Frank M. Travis, Chairman; Miss Agnes Linahan and Mrs. Clifford Blanchard.

Ways and Means—Mrs. Alfred E. Guildford, Chairman; Mrs. Gustave T. Broberg, Mrs. Will Griswold, Mrs. Edward Platt, Mrs. Emil Schweitzer and Mrs. Nicholas Negri.

Social Service—Mrs. Harold Singer, Chairman; Mrs. Karen Kiser, Mrs. Harold Twing, Mrs. Chris Crowley, Mrs. Ralph Wheaton, Mrs. E. Nadeaux, Mrs. Headen Thompson.

Membership—Mrs. William A. Gleeson, Chairman; Mrs. Raymond Bartlett, Mrs. Charles E. Bennett, Mrs. G. T. Broberg and Mrs. Margaret Mulcunry.

Grounds—Mrs. Ernest Howe, Chairman and Mrs. Martin Fitzgerald.

It was also voted to establish a library for patients, and the president was authorized to appoint a librarian and assistants.

Following the business session, the 115 members present, which again sets a new record for attendance, prepared 5000 surgical dressings. The next meeting is to be held on November 18.

The Torrington Registered Nurses Club held a meeting on November 11. Doctor James L. Green addressed the Club on Malformed Teeth Caused by Facial Habits. He showed slides illustrating primitive and modern dentistry.

On Tuesday, November 4, the Men's Club of Trinity Parish held its monthly meeting with a program in honor of Doctor Elias Pratt. The guest speaker was Albert W. Buck, Director of the Charlotte Hungerford Hospital, who paid a tribute to Doctor Pratt's 52 years of practice of medicine in the city of Torrington and his interest in state as well as local health movements. The speaker further outlined the work of the Medical Committee of the State Defense Council. George T. Colt, president of the Club, presided.

At the Annual meeting of the Corporators of the hospital held on October 20, the annual reports were presented. Among the interesting figures were the following:

Total hospital days—37,009 as compared with 35,780 in the preceding year. Average days stay of patients 9.8. There were 567 births of which 295 were males and 272 were females. There were 2,612 x-ray examinations; 26,173 laboratory examinations; 2,736 operations and 23 post mortem examinations.

The Corporators elected John M. Wadhams, 3rd, to fill the vacancy caused by the death of his father, John M. Wadhams. Re-elected to the Board of Governors were: Francis H. Griffiths, Patrick J. Fitzgerald, James W. Roraback, Alfred W. Burg, Howard J. Castle, B. Austin Cheney, Frank J. Damon, William R. Reid, Sanford H. Wadhams and Frederick L. Braman.

The Board of Governors met following the adjournment of the meeting of the Corporators and re-elected the following:

President—Francis H. Griffiths.

Vice-President—Patrick J. Fitzgerald.

Secretary—James W. Roraback.

Mr. Howard J. Castle was elected treasurer to succeed John M. Wadhams; Mr. William Neth was elected Assistant Treasurer and the Torrington National Bank & Trust Company was appointed fiscal agent.

The following Chiefs of Service were re-elected:

Chief of Staff—Harry B. Hanchett.

Chief of Surgical Service—F. A. Weed.

Chief of Medical Service—W. Bradford Walker.

Chief of Obstetrical Service—T. L. Thomson.

Chief of E. E. N. & T. Service—E. S. Hill.

Samuel C. Harvey of New Haven and Augustus R. Felty of Hartford were elected to the Consulting Staff to fill the vacancies caused by the deaths of Timothy M. Ryan and Robert Wadhams. Vincent Vermooten of New Haven was added to the staff of Urologist.

The following Committees were named:

Executive: Francis H. Griffiths, Chairman; Frederick L. Braman, Frank J. Damon, Patrick J. Fitzgerald, James W. Roraback, Carlton H. Talcott.

Finance: H. J. Castle, Frederick L. Braman, Francis H. Griffiths, Frank J. Damon, William R. Reid.

Nominating: Frank J. Damon, Chairman; Patrick J. Fitzgerald, William R. Reid.

Reports of the President, Treasurer, Director and Chiefs of the various services were read and accepted.

Miss Frieda Ritcey, Chief Dietitian of the Charlotte Hungerford Hospital is spending a vacation in Florida between November 15 and December 1. During her absence Miss Christine Balch of Springfield, Mass., is acting as assistant dietitian.

Miss Mary Driscoll, Laboratory Technician, resigned her position at the Charlotte Hungerford Hospital to accept one at the College of Physicians and Surgeons, Columbia University, New York City. She has been replaced by Miss Constance Kennedy of Holyoke, Mass.

Miss Teresa M. Cosgrove of Westboro, Mass., has accepted the position of x-ray technician at the Charlotte Hungerford Hospital. She began her duties on September 22.

MEDICAL PREPAREDNESS

COMMITTEE ON MEDICAL PREPAREDNESS

GEORGE M. SMITH, M.D., State Chairman		CREIGHTON BARKER, M.D., Executive Secretary	
H. BERTRAM LAMBERT, M.D. Bridgeport	FRANCIS A. SUTHERLAND, M.D. Torrington	RALPH E. McDONNELL, M.D. New Haven	DONALD M. BECKWITH, M.D. Rockville
DONALD B. WELLS, M.D. Hartford	CARL C. HARVEY, M.D. Middletown	DANIEL SULLIVAN, M.D. New London	EDWARD J. OTTENHEIMER, M.D. Willimantic
FRANCIS G. BLAKE, M.D. Dean, Yale School of Medicine	STANLEY H. OSBORN, M.D. State Commissioner of Health	LEE D. VAN ANTWERP, M.D. Connecticut State Guard	

DOCTOR ALLAN BUTLER APPOINTED CORPS AREA CHIEF MEDICAL OFFICER IN CIVILIAN DEFENSE

The appointment of Doctor Allan M. Butler of Boston to be Chief Medical Officer attached to the staff of Mr. James M. Landis, Administrator of Civilian Defense for the First Corps Area, has been announced recently. Doctor Butler's experience well qualifies him for this important post. After graduating from Princeton in 1916 he became an officer in the 6th Field Artillery of the 1st Division of the A. E. F. Later he returned to Europe and served with Herbert Hoover in the Polish Relief Commission. Back in America he was in business for a time and then entered the Harvard Medical School from which he graduated in 1926. He then served as a member of the staff of Rockefeller Institute for Medical Research working in research in metabolism, later in the Children's Hospital, Boston, and he is now the Assistant Professor of Pediatrics in the Harvard Medical School. He is a member of the American Pediatric Society, the New England Pediatric Society and the American Society for Clinical Investigation.

Doctor Butler visited Connecticut on Sunday, November 2, for a conference with Doctor Smith, the Chairman of the Society's Committee on Preparedness and the Executive Secretary. It is the purpose of the Society's Committee to integrate medical defense plans in Connecticut with the Corps Area plans and organization, and specific information concerning the developments here have been made available to Doctor Butler's office.

The Doctor in the Navy

E. C. WHITE, Captain, M. C. U. S. Navy
District Medical Officer

For every two thousand officers and men in the navy and marine corps the authorized allowance of medical officers is thirteen. With the present great expansion of the navy, therefore, there has been a greatly increased need for doctors. Many young doctors have joined the regular navy and the naval reserve and many of the older doctors with specialist qualifications have joined the specialist group of the reserve. There are still a number of vacancies both in the regular navy and the reserve.

To qualify for the regular navy doctors must be between 21 and 32 years of age and have completed at least one year of internship. Medical students may take an examination sometime during their third or fourth year for an internship in one of the naval hospitals accredited for the training of interns. At

the end of their internship they are eligible to enter the regular navy.

For the medical corps of the reserve doctors up to 50 years of age may apply. If under 35 they are eligible for the general service group. If between 35 and 50 they are eligible only for the specialist group. The specialist group is organized into hospital units composed of 8 different specialists and one dentist. It is not the Navy Department's intention to call these groups to active duty except in case of general mobilization.

The rank offered to doctors varies with their age, experience and professional repute. Those entering the regular navy and the general service group of the reserve are commissioned as lieutenant (junior grade) with salary of \$2,699 or \$3,158 per year, depending upon whether or not they have dependents. In the specialist group the rank is either lieutenant (junior grade), lieutenant, or lieutenant commander, and the salary ranges from \$2,699 to

\$4,848. The rank of lieutenant (junior grade) in the navy corresponds with that of first lieutenant in the army, lieutenant with captain, and lieutenant commander with major.

The physical requirements of the navy are rather rigid, even in the matter of height, weight, vision, hearing and teeth. The reason for this is, that if an individual becomes physically disabled or if an existing disability is aggravated while on active duty in the navy, he is eligible for a liberal pension or retirement pay.

Medical officers in the hospital specialists units, when called to active duty, will be assigned to naval hospitals in the United States, to hospitals beyond the continental limits of the United States, or to hospital or ambulance ships, and will be used in their specialty.

For medical officers in the general service group and in the regular navy, active duty offers a wide variety of experience in many parts of the world and training in many specialties. They may be assigned to battleships, cruisers, aircraft carriers, destroyers, or hospital ships. They may be detailed for duty at naval hospitals, navy yards, naval training stations, submarine bases, naval air stations, or marine corps bases in the United States or beyond the seas. They may spend most of their period of active duty at the Naval Hospital, Brooklyn, or they may serve with the marines in Iceland, Bermuda, Hawaii, or the Philippines. They may be detailed to the Naval Air Station at Pensacola, Florida, or to the Submarine Base in Alaska. They will have some choice as to where they go and what they do, for the navy permits officers to ask for duty they prefer and assigns them to it if practicable to do so.

Junior medical officers of the regular navy and, to a lesser extent, medical officers of the general service group of the reserve, have opportunities for special training both in naval and civilian institutions. Besides training in the usual professional specialties, medical officers are trained in aviation medicine, industrial medicine, chemical warfare, and in the research problems of diving and submarine warfare.

Doctors desiring information about commissions in the regular navy or naval reserve may obtain it from the District Medical Officer, Headquarters of the Third Naval District, Federal Office Building, 90 Church Street, New York, N. Y., by personal or telephone call or letter. The telephone number is REctor 2-9100.

Station Hospital, U. S. Army Air Base, Windsor Locks

H. G. WOODWARD, *Lt. Col., Air Corps*

In attempting to familiarize the medical profession of Connecticut with the new U. S. Army Air Base at Windsor Locks it is to be assumed that the major interest of the profession would lie in the Station Hospital.

The Station Hospital is a unit comprising thirteen buildings arranged in three flights, with intercommunicating corridors. These buildings lie flat upon the ground, and are surrounded by trees and foliage which were spared during the construction of the unit.

The administration building includes the executive offices, a pharmacy, an x-ray unit, and an operating suite consisting of a large operating room, a sterilization room and a minor operating room, and the surgical dental unit. The x-ray equipment is complete with x-ray table and fluoroscopy unit, and a stereoscopic unit. The operating room is completely equipped, and includes an emergency operating light which is independent of the main electrical supply. Connecting the administration building with the first flight of buildings is a long corridor.

The second flight of buildings consists of four 25-bed wards, and an outpatient department and infirmary, which is complete within itself. These wards are divided into infectious medical, non-infectious medical, surgical, and combination wards. Within these wards are varied numbers of private rooms and offices for the nurses and officers in charge of the respective wards.

The third flight of buildings, with which the second communicates by another long corridor, consists of a supply building, a general mess hall, two enlisted men's barracks, and an infirmary for the Flight Surgeon which is especially adapted for the examination of flying cadets, and in which is housed the complete equipment for these examinations.

On the field there is one more infirmary building which is associated with the hospital, and which cares for soldiers quartered at this particular part of the field.

The organization of the hospital is along two chief lines. The administration of the unit is detailed to the personnel of the hospital, at the head of whom is the Commanding Officer, or Station Surgeon.

Along the professional line the services are divided into surgical, roentgenological, medical, laboratory, dental, dispensary and outpatient service. The surgical service includes general surgery, orthopedics, urology, and ear, nose and throat. The medical service includes general medicine, communicable diseases, and neuropsychiatry. The dispensary and outpatient services include the laboratory, prophylaxis station, and general examinations and treatment. There are two dental units, each one complete, one of which functions in the administration building and deals with dental surgery, and the other in the infirmary which deals with the routine treatments.

The hospital functions through both dispensary and outpatient services, one of which is at the hospital and the other on the field. All patients are admitted to the hospital through these two sources, each in charge of one or more medical officers who make the admission diagnoses.

The hospital has a motor transport service consisting of four ambulances and those trucks necessary for the various supply units. On the field at the present time there are two major tactical units with an ambulance assigned to each unit, one that remains on the flying line twenty four hours a day, and one that remains at the hospital. Each ambulance is completely equipped for first aid and fracture treatment.

The personnel of the hospital consists of twelve medical officers, two dental officers, one medical administrative officer, and ten nurses. The enlisted personnel totals fifty men, and twenty one civilians who are being used chiefly as typists, ward attendants and mess attendants. The commissioned personnel have individual barracks as quarters which are adjoined to the hospital.

Medicine and surgery practiced at this Station Hospital are chiefly and almost wholly preventive in type. On the field there are approximately two thousand soldiers at present, the number increasing weekly, and statistics show that the census of the hospital constitutes about $1\frac{1}{2}\%$ of the total strength of the field. Routine examinations and physical checkups for gonorrhea and communicable diseases take place monthly for the entire command. Each soldier receives immunization injections for tetanus, typhoid, yellow fever, and small pox.

Although the hospital is equipped to care for all emergencies, and facilities are available for prolonged convalescences, those patients who by the nature of their injuries will require more than six weeks con-

valescence, or the treatment of whom requires specialized training, are transferred to the nearest Base Hospital. Transportation is accomplished by train, ambulance or aeroplane.

A point of interest to the profession may be the number of cases appearing at the hospital of men whom the Army finds unfit for service, and the disposal of whom subsequently is a tedious process. Most of these cases are selectees who have gone through the draft boards as physically fit specimens and arrive at Camp with varicose veins, flat feet, chronic asthma and bronchitis, and several mental cases. At this Station, in the past four months, we have had but one case of acute gonorrhea, and as yet a case of syphilis has not been reported.

This Station Hospital through the Commanding Officer extends a most cordial invitation to those members of the medical profession who may wish to visit and inspect the hospital.

Changes in the Selective Service

Special Board for Student Transfers, New Haven

Orville F. Rogers

Matthew Griswold

Joseph Mignone

Special Board, Transferees, Waterbury

Clarence H. Cole

William A. Goodrich

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Board 27C

J. Alexander Clarke added as alternate examiner

Members of the Society Ordered to Active Duty

(As of November 8)

Edward B. Hopper, Glenbrook

Royal A. Meyers, Watertown

Physical Rehabilitation of Deferred Selectees

H. R. 5780 lately introduced by Representative Scrugham of Nevada and now before the House Committee on Military Affairs is a bill to amend section 5 (c) of the Selective Training and Service Act of 1940. If the bill is enacted, the President will be authorized, under such rules and regulations as he may prescribe, to provide for the enrollment in the Civilian Conservation Corps, for the purpose of physical rehabilitation and training, regardless of age limit, of such men as may be deferred for training and service under the Selective Training and Service Act because of temporary physical deficiencies or defects. The President would also be authorized to provide by rule or regulation that when any such enrollee subsequently is determined by the land or naval forces to be physically and mentally fit for combat training and service he shall be inducted immediately into a camp or unit of such forces. Any such period of enrollment in the Civilian Conservation Corps, the bill provides, shall be credited against the period of training and service required under the Selective Training and Service Act and during such period of enrollment the enrollee will be entitled to the pay, allowances, and other benefits provided in that act.

Civilian Defense Resources

According to a joint statement issued on September 4 by the U. S. Director of the Office of Civilian Defense, F. H. LaGuardia, and the Chairman of the American National Red Cross, Norman H. Davis, State and local defense councils are the official agencies responsible for the coördination of all available resources which may be required for civilian protection in the event of belligerent action. Defense Councils should therefore acquaint themselves with the resources of the local Red Cross Chapters in providing food, clothing, shelter, nursing care, transportation, and other basic necessities and should integrate them into the comprehensive local program. Duplication of trained and experienced personnel and of available supplies of the Red Cross

should be avoided except where supplementation is essential to meet the anticipated needs of the community.

Post Graduate Courses in Operating Room Technique and Supervision

The Yale University School of Nursing, in affiliation with the New Haven Hospital, has for some time had under consideration the development of courses in the specialized clinical branches of nursing. Owing to the increased need at this particular time for highly prepared nurses to fill positions in operating rooms, and to meet the needs of national defense, a six months course in advanced work in operating room procedure, and in supervision and teaching, has been organized.

A limited number of well qualified young women will be admitted. The course will include lectures by specialists in general surgery and its various branches as related to the work of the operating room. Practical demonstrations and conferences will be given under the direction of qualified nurse instructors. Opportunity will also be given not only for observation in the operating rooms but for practical work under skilled supervision and instruction.

Applications may be made by registered nurses not over 35 years of age, who have had at least four years of high school, have graduated from an approved school of nursing, and are eligible for registration in Connecticut. No tuition fee will be charged. Maintenance will be provided during the period of instruction.

Application should be addressed to the Dean of the School of Nursing, Yale University, 310 Cedar Street, New Haven, Connecticut.

Plasma Transfusion Saves Kearny Crew Member

On November 4 the United States Navy Department issued a statement telling how blood plasma was used on the torpedoed destroyer Kearny to save the life of a seriously injured sailor. This blood plasma was donated by an unknown American

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through his local Red Cross Chapter to the Army and Navy Blood Plasma Bank. While the destroyer was limping into port a series of three transfusions was performed with plasma flown from shore based supplies by a patrol plane and parachuted into the water from where it was rescued and taken aboard the Kearny.

The ship's sick bay had been wrecked by the torpedo explosion so the wounded man was carried to the ship's afterdressing station where first aid was administered. The transfusions were performed by a U. S. Naval Corps surgeon who arrived by another destroyer, eighteen hours after the accident. The sailor is now recovering at a service hospital in Iceland.

Approximately 20,000 donations of blood plasma have been made to the Red Cross, and of these 9,000 have been processed and turned over to the Navy and 6,000 to the Army. It is estimated that at least 100,000 units are required for each branch of the service to meet ordinary, peace time needs. The nearest blood collecting project is that sponsored by the Red Cross Chapter in New York City.

\$75,000 Grant for Three-Year Study of Health Agencies

The National Health Council, which has served for the past two decades as a clearing house for national voluntary organizations promoting better health, is undertaking a comprehensive study of the activities of all private health agencies in the United States, under a special grant of \$75,000 from the Rockefeller Foundation, it is announced by Doctor Kendall Emerson, president of the Council.

The study will take about three years to complete, and the report will answer such broad questions as the following: What are the various types of state and local voluntary health agencies? What fields do they cover? What methods of coöperation with official health agencies have they established? What do they cost to operate? What types of health work lead to the greatest active participation on the part of the citizens?

The active members of the National Health Council include the following: American Red Cross, American Public Health Association, American Eugenics Society, American Heart Association, American Social Hygiene Association, American

Society for the Control of Cancer, American Society for the Hard of Hearing, Conference of State and Provincial Health Authorities of North America, Maternity Center Association, National Committee of Health Council Executives, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Society for the Prevention of Blindness, and the National Tuberculosis Association.

There are two associate members, the American Nurses' Association and the Foundation for Positive Health; and there are two advisory members, the United States Children's Bureau, and the United States Public Health Service.

The Naked Truth

What has group medicine to offer the incurable chronics of various types and the maimed, deformed, and paralyzed derelicts floating pathetically on a storm-tossed sea of hopeless trouble? Are they to be given the once over? What about Grandma Jones and Uncle Ed who are sitting by the fireside or confined to bed in a dismal back room, waiting timidly but expectantly for the arrival of the golden chariot to bear them aloft? Who is going to prescribe and supervise the pain-relieving measures necessary to their comfort, while an inoperable cancer slowly saps their life? Will the whole technical squad of experts hurry out en masse every time an anxious attendant rings in a three-three alarm? I wonder!

Group medicine enthusiasts must not forget, either, that a lay person is prone to regard his doctor as a machine—a sort of human taxicab—of which he may demand quick service at any hour to carry him or one of his family through some illness, either fancied or real, so long as he pays the shot. What such an individual desires is excellent service and not phoney excuses. He imperatively wants old doc to hurry to his relief as though someone had caught fire from a sunburn and Upandatem, M.D., was a chemical hose company turning out on a still alarm to subdue the conflagration. If group medicine ever arrives, the Lord have mercy on the impatient soul. What he will get will be reversed—excuses and not much service—and I don't mean maybe.

From "Group Medicine Answered," Floyd Burrows, M.D., *N. Y. State Med. Journal*.

"WE'D RATHER BE BOMBED THAN BORED"

Personal interview with Robert D. Gillespie, M.D., R. A. F., by Daniel P. Griffin, M.D.,
Bridgeport

A TALL, lanky, serious but witty British gentleman came to Hartford the other night and outlined to a group of psychiatrists assembled at the Neuro-psychiatric Institute some of England's experiences with, and reactions to modern warfare.

He was Doctor Robert Dick Gillespie, Psychiatric Specialist with the British Royal Air Force. He is in America chiefly for the purpose of delivering the Thomas William Salmon Lectures for 1941 on the general subjects, "Psychoneuroses in Peace and War" and "The Future of Human Relationships." It is emphasized that in his American appearances—which will include visits to New York, Toronto, Chicago, New Orleans, Washington, San Francisco and Philadelphia—he will travel and lecture as a civilian. He is joint author with Doctor David K. Henderson of Henderson and Gillespie's "Textbook of Psychiatry."

Although born abroad where he has been honored by degrees and teaching appointments from leading universities, Doctor Gillespie has many friends in America. He was formerly a member of the faculty of Johns Hopkins Hospital, of the Clinical Staff of the Henry Phipps Psychiatric Clinic and he is still a member of the American Psychiatric Association.

Doctor Gillespie, whose appearance was greeted with much applause, began his talk with characteristic modesty by saying that too much had been made of his own contributions to science in the present emergency and that he received his entertainment with some reluctance, bearing in mind the privations and sufferings of his countrymen abroad. Although he appears shy, he is an easy and graceful speaker. Some of his comments are as follows:

The most remarkable observation is the comparatively small number of psychiatric disorders (among the civilian population) which can be traced to the atmosphere of war. The attendance at London clinics prepared to receive such patients is much less than anticipated. When such difficulties have appeared, they are not essentially different from those seen in time of peace.

So with industrial absentees in bombed areas. The numbers carefully compiled from recent statistics

show no increase due to war. There is indeed a slight decrease in the number of days lost through illness. Another interesting development is the apparent recovery of mental poise by a number of ante bellum sufferers from chronic functional handicaps who have turned to some sort of employment since the war began.

Little difference was noted in comparing statistics as they apply to men and women. In the sector served by Guy's Hospital, more men than women were affected, though the relative risks were identical or nearly so.

Among children, almost no air raid fright was observed. When it occurred it was generally patterned after the type of adult behavior to which the children had been accustomed. Again, the frank cases were seen as a rule among children whose constitutional equipment was a bit below par. This is not to say that there were no cases of fright—and severe fright—among sound children. It is simply stated that the incidence of such phenomena was surprisingly small.

After the lapse of a few weeks (following an air raid) a certain amount of nervousness of various types develops in the population of the bombed area. This, Doctor Gillespie believes, is more readily traceable to the disorganization of their method of daily life than to any direct psychic insult. Indeed, many deliberately choose tasks which offer a certain amount of risk in preference to the idleness which is often a necessary feature of the more protected situations. The explanation is typically British: "We'd rather be bombed than bored."

Children who have been exposed to air raids often suffer from restless sleep and even nightmares. However, on being returned to their homes and after some repetition of the experience, they soon grow accustomed to it. Among adults, it has been repeatedly shown that the threat to life is considered less important than the threat to one's life pattern or the disruption of one's economic set-up.

Among the reaction-types noted, Acute Panic deserves mention. Here immobility is often a feature and the picture may resemble the sudden develop-

ment of a benign stupor. However, the duration may be amazingly short. Doctor Gillespie tells of one such case in which the victim was stuporous in the morning but was busy about his fire fighting duties that night.

Another picture is presented by the "crystallized fear responses" with staring eyes, complete indifference to neighborhood events, and perhaps followed by amnesia of varying compass and duration. The amnesias, which are always interesting, often include unusual features. For instance, in the case of a man who had been buried under a pile of debris it developed that his amnesia was traceable to the fact that he had wet his trousers while thus immobilized. The feeling of shame which accompanied this incident provoked the amnesia. This patient exhibited, as a residual symptom, some incontinence of urine which, however, was readily abolished by narcosis. In general, amnesia is found in two types of cases: (1) those whose experience has been "shattering," to use Doctor Gillespie's term; or (2) those in whom the responsible experience has contained an element which, at least to the patient, has appeared shameful—as in the case referred to above.

For the induction of narcosis, pentothal, evipal or sodium amytal are widely used. The method has been found satisfactory in the management of the amnesias.

Malingering has not been much of a problem, possibly because those weaklings who might have exhibited its symptoms have been weeded out of situations in which it would be profitable for them to appear ill.

The evacuation of civilians, including, of course, children, has brought its own problems. It has not always been possible, in the brief time allowed, to find suitable homes for large numbers of evacuees. The hosts have not been uniformly gracious or tolerant or trained for their new and exacting tasks. The guests have sometimes been ungrateful, suspicious or touchy. Among children, bed wetting, pilfering and other symptoms have been the not very remarkable sequelae in some cases.

These problems are being met. Psychiatric social workers have been active, foster parents have been trained, hostels have been established, and an effort is being made to show just about everybody old enough to realize it that he has a definite place in the war effort. The fact that England is a comparatively small country, with only so much manpower and womanpower on which to draw and that the

tasks are varied, urgent and demanding must be recognized.

Among troops, most nervous illnesses developed in (1) those who were constitutionally predisposed to crack under strain, and (2) those whose suffering, stress or exposure had been unusually prolonged or severe. Fatigue was a factor of primary importance—a view which, of course, is shared by the enemy. Doctor Gillespie says: "The key position for the psychiatrist is in the recruiting and preliminary training of the soldier rather than in treating him after he has broken down." However, he remarked that even in the absence of adequate psychiatric "screening" in the early days of the war, comparatively few members of the flying services developed symptoms of psychiatric interest. This was apparently due to the rigid standards of physique, intelligence and experience which were established early and which eliminated practically all the liabilities.

In explanation of what he meant by unusual strain as a factor in precipitating psychiatric catastrophes, Doctor Gillespie mentioned "six straight crashes." He remarked that a hospital which had been established to care for such disabilities had never been filled and that he had never had more than two dozen such patients at once. Once seriously upset mentally, such patients are seldom ready for military duty again though, of course, they may be useful in the general war effort.

Although present methods of selecting fighting men is less than perfect, it is doubtful if it can be greatly improved. Some features that mark the unfit from a military viewpoint and before induction are: (a) an anxious, timid or something-less-than-daring type of personality; (b) a lack of aggressiveness in make up, a lack of interest in blood, sports, hunting, etc.; (c) an emotionally sensitive make up, likely to be uncomfortable in the presence of minor tragedies, accidents, etc.; (d) poor mixers, emotionally mercurial, unhappy individuals. A well taken psychiatric history will eliminate most of these.

Many of the casualties occurred among those who, on the one hand, had been free from any experience with trauma or, on the other, had survived more than their share. In administrative positions, obsessional types of disturbance were not infrequent after overwork. These did well after a rest-cure. But, in general both in service and among civilians morale has been high and air raids have done little to disturb it. Just before leaving England

Doctor Gillespie wished to confirm (or upset) his own impressions on this point. He 'phoned the Registrar of the Guy's Hospital Sector who reported that this institution had treated less than one hundred cases. He warns us, however, that we may expect a great deal of postbellum disturbance of this sort.

One of the most interesting features of the meeting was the exhibition of a moving picture film showing the methods employed in what we would call a Reconstruction Hospital. This institution in Sussex has treated about twenty five hundred patients in the past two years. Of these, forty one were civilians. Attention to the physical needs of the inmates was emphasized and, for those prepared for it, setting up exercise of farm work was prescribed.

For the malnourished, insulin in doses of 10 to 80 units was employed, care being exercised to avoid deep sleep. For the anxiety type of psychoneurosis, narcosis was commonly employed. Somnifaine, paraldehyde, amytal were among the drugs used and sleep was continued for 20 or 24 hours. A solution of glucose was given by mouth—100 fluid ounces in 24 hours. Such treatment might be maintained for a period of five to ten days with a careful check of fluid intake and output maintained throughout the period of narcosis.

Functional amnesias are common among sailors, uncommon in the Air Force. Narcosis, induced by the intravenous use of a barbiturate, is often effective in the task of memory restoration. Hypnosis is successful but is open to the objection that it takes too much time. Combinations of the various therapies mentioned are often useful.

But treatment often fails to equip a man to return to the fighting front. In Doctor Gillespie's words: "If esprit de corps didn't keep them in shape to fight, it is unlikely that psychotherapy will make warriors out of them." Again, he warned against the selection of men who appeared unduly sensitive to fatigue.

Despite his heavy schedule, Doctor Gillespie volunteered to answer questions from the audience:

"Will the transplanted children be regarded in later life as cowardly and treated as such?" Some parents feel so and this is one reason for their reluctance to consent to such a transfer. "How will children feel about returning after long absence from home?" This is uncertain, of course, especially since it is not known how nearly the new home may resemble the old. "Is the admitted disregard of life exhibited by the Nazi troops induced by the use of some drug?" Probably not, it is simply the result of their training. "Are cognac or other drugs used to 'keep 'em flying' in the R. A. F.?" No. "Are any special age groups predisposed to war neuroses?" No. "Has there been any mass panic in London, for instance, during air raids?" No. Most of the people did not go underground at all. "What effect has the war had on the consumption of alcohol?" Comparatively little. More beer drinking largely to neutralize boredom. No wine is imported and most of the distilled liquor is exported. The young men are said to be better behaved than they were in the last war.

Squibb Stilbestrol Released for Sale

After two years of clinical trial, during which time over a hundred papers were published reporting studies in which it was used, Stilbestrol manufactured by E. R. Squibb & Sons, New York, is now offered for sale to the druggists of the land. Stilbestrol is a synthetic estrogen possessing the physiologic properties of estrogenic substances derived from natural sources. Chemically, it is alpha, alpha'-diethyl-4, 4'-stilbene-diol. It is also called diethylstilbestrol.

Stilbestrol orally has a ratio of effectiveness to intramuscular injection much superior to that possessed by natural estrogens. It has another advantage over the natural estrogens in that it is considerably more economical.

Squibb Stilbestrol is supplied in three forms:

Compressed tablets, either uncoated or enteric coated (for oral administration) containing 0.1 mg., 0.5 mg., 1.0 mg. or 5.0 mg. in bottles 25, 100 and 250.

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PUBLIC AFFAIRS

STATE CARE OF VETERANS

The care of the sick and disabled by agencies of government is becoming an increasing factor in medical practice. Veteran soldiers have long been a favored group in government care. The State of Connecticut has recently opened the great new State Veterans Home at Rocky Hill where extensive hospital facilities are available for the care of residents. The Chairman of the Veterans' Home Commission is Doctor Charles H. Sprague, of Bridgeport, a member of this Society and PUBLIC AFFAIRS is pleased to present a discussion of the purposes and operation of the Veterans Hospital by Doctor Sprague. This article is condensed from a Vice-Presidential address presented before the Fairfield County Medical Association.

Fitch's Home for the Soldiers, Noroton Heights and Veterans' Home, Rocky Hill

CHARLES H. SPRAGUE, M.D.

Chairman, The Veterans' Home Commission

Fitch's Home for the Soldiers was established in 1864 through the generosity of the late Colonel Benjamin Fitch, a philanthropic citizen of the Town of Darien, who gave a plot of land, consisting of five acres, with a building thereon, to be used for the care of orphans of soldiers who served in the Union Army during the Civil War. The Home was incorporated by an act of the General Assembly of that year.

The management of the Home was by a Board of Trustees, who were empowered to receive, hold and use, for the purpose specified, a proposed endowment from the donor of the land and other property which was duly conveyed to the Board of Trustees, so established.

The policy of caring for these orphans was continued until 1887, when provision was made for the care and treatment of veterans of the Civil War and later the benefits of the Home were extended to veterans of other wars and campaigns in which the United States was engaged and recognized as such by the War and Navy Departments, and to any veteran who served in or with the Forces of any Government associated with the United States in

the World War between April 6, 1917 and November 11, 1918, or in the United States Military Forces in Russia at any time between April 6, 1917 and April 1, 1920, provided that any such person who was not a resident or a resident alien of this State at the time of his enlistment or induction into such service shall have resided continuously in this State for at least two years.

All such male veterans are entitled to admission to the Home and the Veterans' Home Commission may expend from its general appropriation such sum of money as may be necessary, within statutory limits, to suitably care for and maintain at her residence or in a hospital or other suitable place in the State, any female veteran.

The advent of the World War presented a problem to the State and recognizing that there were about 65,000 men from Connecticut who served with the Armed Forces of the United States, it was realized that Fitch's Home for the Soldiers was inadequate for the care and treatment of disabled, worthy veterans. The 1931 General Assembly, after full consideration of the problem, decided that a new Veterans' Home and Hospital should be had and enacted a law appointing the Veterans' Home Building Commission empowered to acquire a site, construct and equip a new Facility and made an initial appropriation of \$250,000 for this purpose.

One hundred and fifty-seven sites were offered. Many of these were eliminated as unsuitable and

after inspection of fifty-seven of the sites, one consisting of 310 acres, with ten buildings thereon, off from the main highway in the Town of Rocky Hill, was purchased for the sum of \$50,000 in January 1932.

The demand had become so great that a branch of Fitch's Home for the Soldiers was immediately established and the buildings were used to house seventy-five veterans and for farm purposes. The veterans requiring care increased in numbers to a point where it was necessary to establish a second branch Home, which was done at the Groton Airport and two hundred veterans were provided for at that location.

A consulting architect was retained and an architectural competition was conducted under rules of the American Institute of Architects. Plans were submitted and a jury consisting of qualified persons outside of the membership of the Building Commission selected the plans prepared by Mr. Douglas Orr, Architect, of New Haven, and the Commission approved his plans and made the award to him. Surveys and engineering work were done; a water and sewage system installed and a root cellar constructed. Requests were made to the General Assembly, Sessions of 1933 and 1935, for appropriations for construction and equipment, but the funds were not provided. Final plans and specifications, together with an estimate of the cost, were submitted to the General Assembly, Session of 1937, and the construction was approved as a part of the State's Institutional Building Program, adopted that year, to be carried out by the Public Works Department, which was created by the General Assembly.

The construction of the new Veterans' Home at Rocky Hill was completed to a point to permit occupancy on August 28, 1940, and on that day the personnel was transferred from Fitch's Home for the Soldiers, which was closed as such and the custody of the real property turned over to the State Military Department, and it was subsequently leased by the military authorities to the United States Navy Department who since that time and at present are conducting a United States Naval Reserve Radio School on the premises.

The Veterans' Home at Rocky Hill was officially dedicated on September 14, 1940; dedicatory exercises were held and the custody of the property turned over to the Veterans' Home Commission, which is the board of management and consists of

eight members, two members being appointed by the Governor of the State of Connecticut biennially for terms of eight years each from the first day of July in the year of their appointment.

The real property consists of 310 acres and 46 buildings, valued at \$3,007,000. The bed capacity is 284 hospital and 776 domiciliary; total capacity 1,060.

The Mess Hall, Kitchen and Commissary building, Power House and Laundry building, Shops, Garages and Assembly building are of such size as to meet the eventual requirement of an anticipated population of 2,100 on the basis of 3% of the men from Connecticut in the World War, and both barracks buildings are constructed to permit an additional construction of wings as required.

The Hospital unit is a general medical and surgical one and includes facilities for all kinds of physical therapy (hydro and electric), major surgery and dental operating, and contains a dental laboratory, medical laboratory, special treatment rooms and 1, 2, 3 and 6 bed wards, and has complete modern equipment.

The Resident Medical Staff consists of a Chief Medical Officer, 2 assistant Medical Officers and 2 Assistant Physicians; and an Attending Staff comprised of outstanding men of the medical profession in their respective fields from the nearby cities of Hartford and Middletown, who provide the following services: Surgery, Medicine, Bronchoscopy, Cardiology, Dermatology, Eye, Ear, Nose and Throat, Gastro-enterology, Neuro-surgery, Pathology, Orthopedics, Urology, Psychiatry and x-ray. The full time services of a Dentist are had two days each week and that of an Ophthalmologist one day each week.

A Consulting Staff is about to be appointed.

Also on the Resident Hospital Staff are a Medical Laboratory Technician, Dental Hygienist, Dental Technician, X-ray Technician, Physical Therapy Technician, Dietitian, Pharmacist and Medical Record Librarian. The Nurses Staff consists of a Superintendent of Nurses, Head Nurse Supervisor, 3 Head Hospital Nurses, 6 Hospital Charge Nurses, 1 Surgical Nurse Supervisor, 10 Graduate Nurses, 14 Orderlies and Clerical and Administrative staff.

Daily sick call is held and the men on domiciliary care report to the clinic in the Hospital to receive medication and treatment. At present 3 weekly clinics are conducted; namely, Cardiac, Luetic and

Varicose Veins, and others are in the process of organization.

Qualifications for membership in the Home are the same as were formerly required at Fitch's Home for the Soldiers, and every veteran, on admission, is referred to the Hospital where he receives a complete physical examination, including dental, and, contingent on the findings, becomes a hospital patient or is assigned to domiciliary care in the barracks. Members are classified on admission by the Medical Staff for free detail labor according to their physical ability. A detail roster is maintained and the members are required to perform free work according to their classification.

The turn over in population for the first year was approximately 2,000 and the average daily population during the winter was 650, which has decreased to 459 by reason of the seasonal exodus and existing industrial conditions during the present emergency under which many veterans not employable under normal conditions have been given work.

The Home is a member of the American Hospital Association and has been selected by the Hart-

ford County Medical Association to be at the disposal of the Administrator of the Connecticut State Defense Council, the Commissioner of State Police and the directors of the various Civilian Hospitals, for the purpose of absorbing an indefinite number of evacuees from civilian hospitals in the County or to receive direct the victims of disaster, if such should occur in this highly industrialized area engaged in the manufacture of vital national defense requirements.

It is a timely question to ask, what will be the policy of the Federal and State government in relation to the care of soldiers discharged from the present training army? Will the State have to extend its provisions for hospitalization and domiciliary care to include these new peace time soldiers? Will the expense of all medical care for them be a public responsibility? The extension of military training and through it the increase in the number of persons who in the past have been considered wards of the government bring new problems in medical care.

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Departure and Adherence

An event marking a milestone in the forward progress of Connecticut industrial medicine occurred with the formal opening on November 12 of the "Model Industrial Medical Department" of the New Departure Division, General Motors Corporation, Bristol. Attractively decorated, efficiently designed, and completely equipped, the department is in more than one sense "a new departure."

At a dinner held at the plant to which members and friends of the Bristol Medical Society were invited and at which Ralph A. Richardson was toastmaster, Martin I. Hall, plant Medical Director, expounded the medical program of his department. "Our policy is as nebulous as the British Constitution," he said. "We have an ideal to which we try to adhere. Many of our employees and many of our executives do not fully understand our purpose, nor do they know why we have such an elaborately equipped and beautifully laid out department."

"We consider the healthy worker not only a going asset as far as the company is concerned, but as far as the community is concerned. It has been pointed out this evening that there is great waste when a man is away from work because of illness. His machine stands idle. The invested capital represented by the machine earns no money."

"Just so, there is a community loss, which far exceeds the loss to the company. As a taxpayer he becomes handicapped through his illness in his support of the school, of the church, of the community chest, of his home. It is largely to prevent these multiple losses that our department functions. This might be said to be the present policy of our department and we shall adhere to it, but if it becomes necessary to change it in the future, we shall."

The guest speaker was Clarence D. Selby, Medical Consultant for General Motors Corporation and Chairman of the sub committee on Industrial Health under the new Procurement and Assignment Service in the Office of Defense, Health and Welfare Services at Washington. Doctor Selby emphasized the fact that the new medical quarters at the Bristol New Departure plant are symbolic of the new relationship existing between the medical departments of industry and the medical profession. Both have one objective in view, the prevention of disease and the maintenance of health. Doctor Selby called attention to the large amount of time lost by employees from non occupational illnesses. The Owens-Illinois Company reported in 1940 23,700 absences from work in the employee group of 14,580. Of these only 1% were due to occupational injuries and diseases, while 59% were caused by non occupational injuries and sicknesses. 31% asked to be absent and 9% were absent without explanation. The General Motors Corporation figures, as quoted by Doctor Selby, were based on disabilities of eight days and more. In a total of slightly less than 188,000 hourly rated workers, male and female, 21,173 were disabled from non occupational causes of a physical nature, injuries and sickness, some time during 1940 (for eight days and longer). This is in excess of 11%. The total number of days lost was in excess of 828,000, the average loss of time per case was 39.2 days and the average loss per employee was 4.42 days. Appendicitis, non occupational injuries, genitourinary diseases, influenza, and tonsillar infections head the list of causes of this loss of time.

All this but emphasizes, as Doctor Selby stated, that the biggest job the medical profession has today is that of reducing the time lost from non occupational diseases. This will be the greatest contribution



First Aid Dressing

to defense in the United States which the profession can make.

Frederick G. Hughes, General Manager of the Division, stressed the cordial relations existing between the company's medical department and the practicing physicians of Bristol and nearby communities. This was the tenor of the remarks of numerous speakers, including James D. Gold, President of the Connecticut State Medical Society, and Arthur B. Landry, Thomas P. Murdock and Cole B. Gibson. Compensation Commissioner Leo J. Noonan said it was a rarity, if not entirely unknown, for a New Departure employee to appear before the Commission for adjudication of a compensation claim, settlement invariably occurring by agreement between the worker and the company.

In a booklet distributed at the dinner the department is described as follows:

"It is not a deserted, idle institution. Operating 24 hours a day, six days a week, the medical department in 1940 had some 60,000 visits from employes, and at the present rate more than 90,000 calls are expected to be made in 1941.

"The range and variety of cases is enormous, extending from malingerers to those suffering from

compound fractures. However, minor cuts, bruises, sprains and the like bulk largest on the list. Headaches, colds, indigestion and other minor ailments, for which the employe would not ordinarily consult his family physician, are regularly treated. In addition, minor operations are performed; thousands of x-rays and blood tests are given; and complete records of all cases are kept.

"Plant hygiene is prosecuted as vigorously as patient treatment. Working with engineers, the medical department sees to it that atmospheric and other conditions are safe and that the plant buildings are free of harmful dusts and fumes. A constant vigilance is maintained to assure New Departure employes of freedom from occupational diseases.

"While determining the fitness of applicants for work, the medical department frequently uncovers signs of disease in its incipency and is able to refer patients to their family physicians to check further contagion and take immediate steps towards complete cure. Asymptomatic tuberculosis and other diseases have been discovered during these examinations. In 1940 some 950 pre-employment examinations were made, and thus far this year in the midst of the tremendous national defense employment upswing more than 2,260 tests have been made.



"From a location where walls were drab and noise was unavoidable from machines overhead the department moved to its new, quiet quarters early in October of 1941. Extensive use of color is found throughout the department today. Walls are in pastel shades of tan, yellow and green; floors are covered with varicolored linoleum and asphalt tile; fluorescent lighting not only gives the best available illumination, but also enhances the color schemes. Well appointed rooms are set off with venetian blinds and in the first aid division a large glass block panel assures more light and more attractive surroundings. Temperatures are kept constant with an individual air and heat-conditioning unit in the basement. New Departure has sought to make things as comfortable and cheerful as possible for its employees who are sick or injured.

"Besides the first aid room, which is centrally located in the medical department, the medical department has an x-ray plant of three rooms and a viewing room; a physical examination room; reception and file room; waiting room; two doctor's offices; male ward with three beds and attached washroom and toilets; female ward with two beds and lavatory; eye room; operating room; physiotherapy room; sterilizing room; and nurses' rest room.

"The equipment in these rooms is second to none anywhere in industry. The x-ray apparatus is an example. Included in this part of the department's inventory are a radiographic and fluoroscopic diagnostic x-ray machine which is shock-proof and has a handy tilt table; a second mobile and dental unit; a dark room thermo compartment tank, a Frigidaire cooling unit, 24-film capacity dryer, a built-in linoleum covered loading bench with cassette bins below, a cassette transfer cabinet, etc.

"In the way of equipment the medical department also boasts an electrocardiograph-stethograph for heart examinations; a "project-o-chart" for eye examinations; an unique central treatment table of four separate sections so that four patients may be treated simultaneously by as many nurses; and foot-baths, armbaths, arm and leg whirlpool baths, nose and throat chairs, short-wave diathermy units, ultra-violet lights and infra-red light, high pressure water sterilizer, utensil sterilizer, instrument sterilizer and high pressure autoclave."

In surroundings as modern as these, it is believed that the New Departure medical department will continue to "depart" from outworn methods, while adhering to the best in industrial medical practice.

THE FORUM

With the discovery of tetanus antitoxin in 1892 it was confidently expected that the death rate from the disease would be negligible, if not actually abolished. But, paradoxical as it may seem, no such thing happened. Recent surveys confirmed a long standing suspicion that, if anything, the rate was higher.

The explanation of this seeming paradox lies in several interrelated factors: improper use of the serum, neglect of fundamental surgical principles, and an incomplete knowledge of the production and dispersion of the toxin. Since no improvement in the rate could be expected without correction of these errors, experimental and clinical work were directed toward a better understanding of the basic pathological problem, plus a more efficient use of the weapons at hand.

The first offensive was aimed at perfecting an agent that would produce an active immunity to the disease. This has been accomplished and is now available as a toxoid. It is given in exactly the same way as the one for diphtheria. Moreover, there is evidence that a so called "refresher" injection given at the time of injury mobilizes the antigenic factors already present in the body. All men in the military services are receiving this prophylaxis now.

A second offensive was directed at the management of the wound and the proper use of antitoxin. While each wound is a law unto itself, where possible a rigid schedule of treatment was followed. Thorough cleansing and debridement, accurate hemostasis, primary closure and immobilization in plaster became the standard procedure. More recently this was amended to include the introduction of one of the sulfonamides into the wound. In a few cases, when doubt existed about adequate debridement, the wound was packed lightly with vaseline gauze and immobilized. The experiences of Trueta in the Spanish Civil War and the British surgeons in the present one have confirmed the soundness of

this technique. Furthermore, they have demonstrated that this therapy is an effective deterrent to gas gangrene.

The time lapse after the injury governed the use of antitoxin. When the patient received attention within the first six hours, a dose of 5,000 to 10,000 units was given immediately after the surgical procedures were completed. On the other hand, if a longer period had elapsed, no manipulation was attempted until an hour after a minimum of 50,000 units had been injected around the wound.

The final offensive was aimed at improving the care of the tetanic patient. The discovery that the toxin is formed at some focal point—usually the site of injury—and distributed by the circulation, revitalized the efficiency of known therapeutic weapons. Today's treatment is centered on (1) attenuating the toxin already fixed in the nerve cells by proper sedation and supportive measures; (2) blocking the suspected area by encircling it with injections of antitoxin totaling a minimum of 200,000 units; (3) surgical drainage of that area and immobilization of the part; (4) continuous intravenous drip of antitoxin in saline and glucose to neutralize any circulating toxin. All this was done in the first 24 hours of the disease. After this period the patient was not disturbed except for needed care.

Although the usual cry is "Doctor, how can I reduce some weight," an occasional patient does walk in that wants to put some on. Blotner at Peter Bent Brigham seems to have found a reasonable and effectual method. After examination proves they are thin but healthy, he prescribes 10 units of insulin three times a day. The results were most gratifying. The patients felt stronger and more active; the appetite increased and they had a greater relish for food; best of all they gained rapidly up to the approach of normal. As this was reached the rate slowed down. Since this gain was represented by substantial fat deposits, it stayed with them for some time after treatment was stopped.

T. P. R., M.D.

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NEWS

from County Associations

Fairfield

At the first fall meeting of the Norwalk Medical Society held at the Norwalk General Hospital the following slate of officers were elected for the year: President, Charles W. Perkins; Vice-President, Grace V. Gorham; Secretary, Wesley F. Fitzpatrick; Treasurer, John R. Heafey.

David N. Barrows of New York City addressed the Bridgeport Medical Society on the subject of "Pelvic Floor Repair, When and How." This meeting was held on the evening of November 4 and had to compete with a parade held to celebrate the election of Jasper McLevy to his fifth term as mayor. Notwithstanding, the meeting was well attended and the paper excellently presented.

At the annual meeting in Boston, Mass., Reinhold F. Hertzberg and A. Frederick McGourty, of Stamford, were elected Fellows of the American College of Surgeons.

Brian C. Sword, Director of Anesthesia at the New York Polyclinic Hospital, New York City, addressed the members of the Stamford Medical Society at its regular meeting on November 11. Doctor Sword gave a discussion of anesthesia that was well received by all present. The subject of his paper was, "What the Surgeon Expects of the Well-trained Anesthetist."

The Norwalk Medical Society had as its guest speaker for the November meeting, Charles Gordon Heyd, chief surgeon of the Post Graduate Hospital of New York. He spoke on the "Progressive Characteristics of Gall-Bladder Disease."

Hartford

On Thursday, October 16, at the Avon Country Club, the semi annual meeting of the Interne Alumni Association of St. Francis Hospital was held. The weather was excellent and golf was played by many of those attending. Samuel Maranzini was the winner of the low gross prize with 88 and Andrew Resnisky received a consolation prize for high gross of 110. The champions of the quoits pitching were Lewis James and Thomas F. Murphy. A banquet was held in the evening following which there was enter-

tainment by a professional group. There were various door prizes donated by merchants in Hartford and West Hartford.

Howard K. Gray of the Mayo Clinic was a guest of the Hartford Medical Society on November 3. He gave a very interesting clinic at the Hartford Hospital at 5:00 P.M. at which several interesting cases dealing with lesions of the stomach were presented and discussed. His evening presentation was equally worthwhile. At this he discussed conditions of the liver and biliary tract.

McLeod C. Wilson of Hartford, medical director of the accident and group department, Travelers Insurance Company, addressed the Association of Life Insurance Medical Directors of America in New York recently on "Heart Tolerance Following Coronary Episodes."

Middlesex

Anthony Apuzzo of the Connecticut State Hospital Staff and Lieutenant in the United States Medical Reserve Corps has received his call to active duty. He reported on November 17 at the Naval Training Station, Newport, Rhode Island.

Ella Wilder who has been ill at her home on South Main Street, Middletown, for some time is now a patient in the Baker Memorial division of the Massachusetts General Hospital in Boston.

The Central Medical Association met at Bengston-Wood Hall in Middletown on November 10. Christie McLeod, pathologist at the Middlesex Hospital, spoke on "Certain Pathological Aspects of Kidney Disease."

New Haven

The one hundred and fifty-eighth semi-annual Meeting of the New Haven County Medical Association was held at the Waterbury Country Club on October 23. George M. Smith, Chairman of the Connecticut Medical Preparedness Committee, reported to the Association on the work of the Committee. Fourteen candidates were elected to membership, six former members were reinstated and two new members were accepted by transfer. After the business meeting, Cornelius P. Rhoads, the Director of Memorial Hospital, New York City, spoke to the members on "The Story of the Procurement of Blood Substitutes for Britain and the Armed Forces of the United States." The Semi-Annual Dinner of the Association was attended by

125 members who heard an address by Professor Walton H. Hamilton of the Yale School of Law. Mr. Hamilton spoke on "Medicine and the Anti-Trust Act." Frederick N. Sperry, New Haven, presided at both meetings.

The fall meeting of the New England Proctologic Society was held in New Haven on October 24, Simon B. Kleiner being host. The next meeting of the Society will be held in Boston in April 1942.

At a national convention of the Probus Clubs held in New Haven on October 26, Maxwell Lear, New Haven, was chosen National President for the coming year.

The regular monthly meeting of the Waterbury Medical Society was held on November 13 at which time Abram Myerson of Boston addressed the Society on "Electric Shock Therapy in the Depressive Mental States."

The Hezekiah Beardsley Pediatric Club, the Pediatric Section of the Connecticut State Medical Society, held a meeting at the Southbury Training School in Southbury on November 5. Ernest Roselle, Superintendent, and Herman Yannet, Medical Director of the School, were hosts to the Club and presented a most profitable and interesting program. Members and their guests were taken on a tour of the School by Doctor Yannet, following which members of the Staff conducted a clinic in which several instructive cases were shown and the opportunity to study mental deficiency in such an institution was stressed. After dinner the Club was addressed by George Humphries, Medical Director of Letchworth Village, Thiels, New York, on "The Social Problem in Mental Deficiency." The following officers were elected: Ernest Caulfield, Hartford, President; Edward T. Wakeman, New Haven, Treasurer; and Herman Yannet, Southbury, Secretary.

The New Haven Medical Association will be addressed on December 3 by Lyman W. Crossman of New York City. On December 17 the annual Christmas party of the Association will be held. According to custom, the scientific program will be omitted and entertainment of a definitely non scientific type will be offered. This meeting is limited to members of the Association.

The October 1941 number of *The Journal of the Missouri State Medical Association* contains a paper on "The Significance of Hypertension and Renal Disease" by Clyde L. Deming of New Haven. This

paper was presented at the 84th Annual Session of the Missouri State Medical Association at St. Louis in April.

The Weekly Roster and Medical Digest informs us that a capacity audience was on hand in Philadelphia on the evening of October 15 to hear John R. Paul of New Haven, J. Moore Campbell and A. Bruce Gill of Philadelphia present the subject of poliomyelitis.

New London

Frederick Hartman of New London, junior attending surgeon Lawrence Memorial Hospital, was elected a Fellow of the American College of Surgeons at the recent meeting in Boston.

The regular monthly scientific meeting of the New London County Medical Association was held at Uncas-on-Thames, November 6, at 8:30 P.M. More than fifty members attended. Ashton Graybiel of Boston, instructor in Cardiology, Harvard Postgraduate Medical School and visiting cardiologist, Massachusetts General Hospital, spoke on "Heart Pain." Doctor Graybiel's talk was very interesting and instructive. An unusually long question and answer period was evidence of the great interest on the part of the members in this subject. Preceding the meeting a dinner was held for Doctor Graybiel at the Norwich Inn. The next scientific meeting of the New London County Medical Association will be held at Uncas-on-Thames, December 4, at 8:30 P.M. Champ Lyons, Massachusetts General Hospital, Boston, will speak on "Chemotherapy." Doctor Lyons is a well recognized authority on this subject and will be worth hearing. All physicians are welcome.

Joseph L. Daly has joined the medical staff of the Norwich State Hospital. Doctor Daly received his early education in the schools of New York City and graduated from Manhattan College, New York, receiving his bachelor of science degree in 1929. He later entered New York University and Bellevue Hospital Medical College, receiving his medical degree in 1933. He completed his internship at the Willard Parker Hospital at New York City. He has had extensive psychiatric experience and has been resident psychiatrist at the U. S. Marine Hospital, New York. He later was assistant physician at Connecticut State Hospital at Middletown and in 1937 he joined the staff of the Hudson River State Hospital at Poughkeepsie, New York. In 1938 he was

senior resident physician in the department of psychiatry at Yale University. Prior to his appointment to the Norwich State Hospital he was with the U. S. Veteran's Administration at Northampton, Mass.

Charles Serbst, a Resident on the surgical staff under Doctor Urquhart at Uncas-on-Thames, is now doing similar work at the State Sanatorium, Rhode Island. Our best wishes for a successful service.

The Norwich State Hospital has organized a Department of Psychology for the purpose of assisting the administrative and psychiatric staffs in their work of treating mental illness. The department has three chief functions: the use of objective psychometric methods in the collection of clinical information for the psychiatric staff; research in the applied problems of psychopathology; and educational work with the hospital personnel and the hospital's community.

At the present time the staff of the Laboratories of Psychology includes Florian Heiser, PH.D., Director, Robert B. Malmö, PH.D., and Julian B. Rotter, PH.D., Institution Psychologists.

Tolland

The regular semi-annual meeting was held at Somers, on October 21, with President Walter Haviland in the chair. James D. Gold of Bridgeport, Roy L. Leak, Middletown, and Herbert Thoms of New Haven, outlined the coming sesquicentennial of the State Medical Society to be held in Middletown next June. This promises to be an interesting and memorable occasion. James R. Miller reviewed the activities of the Council, Arthur B. Landry spoke a few words of salutation and Stanley Osborn discussed the rising tide of work which the defense activities throw upon the Health Department. Creighton Barker, speaking for George Smith, chairman of the State Committee on Medical Preparedness, who was unable to be present, traced the beginnings and accomplishments of the State Medical Society's relationship to the national defense effort. The speaker of the evening was William L. Higgins of South Coventry. His audience was treated to numerous interesting anecdotes about the practice of medicine fifty years ago.

Fairfield State Hospital Laboratory

The Laboratory of the Fairfield State Hospital at Newtown has just completed its first year of operation. It is situated in a separate two-story building which was completed and equipped during the summer of 1940. The laboratory proper, together with the pathologist's office and a small museum room, occupies the second floor. On the first floor are the autopsy room and receiving room with intervening electrically refrigerated mortuary cabinets, a photography room with adjacent dark room, and the hospital pharmacy. In the basement are storerooms and an animal room, also a room in which are situated an autoclave, incinerator and water still.

The procedures carried out in the laboratory include the usual techniques in hematology, urinalysis, blood chemistry, bacteriology and serology, as used in any good general hospital laboratory. Modifications are introduced as befits the nature of the institution. For example, in the case of spinal fluids, quantitative protein estimations are done routinely by a modification of the method of Denis and Ayer, using a photo-electric colorimeter. Wassermann and colloidal gold tests are also done routinely. The laboratory has been approved by the State Department of Health for the examination of body fluids, secretions or excretions under Regulation 40-A, and for performing a standard laboratory blood test for the marriage license law under Regulation 40-B.

The laboratory staff consists of a director, assistant director and three technicians. The director and assistant director both hold part time teaching positions in the Department of Pathology of the Yale School of Medicine. In this way a relationship of mutual benefit is maintained between the hospital and the medical school.

Research problems already under way include a study of senile changes in the brain by silver impregnation methods, an attempt to produce gastric ulcers experimentally in guinea pigs by means of drugs, and a study of the effect of various procedures on the survival of mice infected with neurotropic virus. Some attention is being given to the presence of ether-soluble pigments in the urine of alcoholic patients suffering from vitamin deficiency. Other problems dealing chiefly with the blood chemistry in different psychoses are under consideration.

SPECIAL NOTICES

MEETING OF COMMITTEE ON INDUSTRIAL HEALTH

Graduate Club, New Haven, Friday, December 5,
6:30 P. M.

The agenda will include a discussion of the following:

1. "Medical Service in Connecticut Industry." Analysis of replies to questionnaires submitted to members of Manufacturers Association of Connecticut.
2. Industrial Health department in Connecticut State Medical Journal.
3. Industrial Health Section program—Sesquicentennial Meeting, Middletown, June 3, 1942.

MEETING OF THE ASSOCIATION OF CONNECTICUT TUMOR CLINICS

St. Mary's Hospital, Waterbury, December 11, 1941,
at 4:00 P. M.

1. X-ray Diagnosis and Treatment of Carcinoma of the Colon. By P. F. Butler, M.D., Chief Roentgenologist, Boston City Hospital, Boston, Mass.
2. Selection of Operation for Cancer of the Colon. By R. B. Cattell, M.D., Lahey Clinic, Boston, Mass.
3. Ten Year Study of Carcinoma of the Colon at St. Mary's Hospital. By J. F. Burke, M.D., Waterbury, Conn.
4. Discussion to be opened by M. J. Lawlor, M.D., Chairman Tumor Clinic, Waterbury, Conn., and S. Atkins, M.D., Roentgenologist, Waterbury, Conn.

A buffet supper will be served immediately following the meeting. All physicians in the state are urged to attend this meeting.

AN INSTITUTE ON MORALE AND MENTAL HYGIENE

Under the auspices of The Connecticut Society for Mental Hygiene and The Connecticut Society for Psychiatry and Neurology

Friday, December 12

Sterling Law Buildings, Yale University

PROGRAM

- 3 P. M. Section Meeting A (Room 153)
Conducted by The Connecticut Society for Mental Hygiene.
1. When Both Parents Work.
By Miss Esther M. Jacquith, Director, Childrens Division, Family and Childrens Service, Stamford.
Discussion from the floor.
 2. Escapes from Anxiety.
By George K. Pratt, Medical Director, Conn. Society for Mental Hygiene.

3. Establishing Emotional Security.
By (Speaker to be announced).
Discussion from the floor.

4 P. M. Section Meeting B (Room 113). Round Table.
Conducted by the Connecticut Society for Psychiatry and Neurology

Moderator: Lieut. Colonel William B. Smith, State Medical Officer, Selective Service System

"Psychiatry and Selective Service Examinations"

DISCUSSANTS

- William A. Bryan, Superintendent, Norwich State Hospital.
Charles C. Burlingame, Director, Hartford Retreat.
James M. Cunningham, Director, Bureau of Mental Hygiene, State Department of Health.
Richard Goldstein, Assistant Clinical Professor of Psychiatry and Mental Hygiene, School of Medicine, Yale University.
Arthur H. Jackson, Psychiatrist, Waterbury.
Eugen Kahn, Sterling Professor of Psychiatry, School of Medicine, Yale University.
Clifford D. Moore, Superintendent, Fairfield State Hospital; President, Conn. Society for Psychiatry and Neurology.
Lloyd J. Thompson, Associate Clinical Professor of Psychiatry and Mental Hygiene, School of Medicine, Yale University.
William B. Terhune, Director, Silver Hill, New Canaan.

EVENING MEETING

Auditorium, Sterling Law Building, Yale University
8:15 o'clock

Chairman, Colonel Samuel H. Fisher, Administrator, State Defense Council

Program

1. How to Wage a "War of Nerves."
By Kimball Young, Ph.D., Professor of Sociology, Queens College, N. Y., and Collaborator in "German Psychological Warfare."
2. Selecting Soldiers for Stability.
By Harry Stack Sullivan, Consultant in Psychiatry, U. S. Selective Service System, Washington, D. C.
3. Keeping Up the Family Morale.
By (Speaker to be announced).

ORGANIZATION MEETING, SECTION ON GENERAL MEDICINE

The organization meeting of the Section on General Medicine of Connecticut is to be held December 18, at 8:00 P. M. at the New Haven Medical Society, Whitney Avenue. This meeting is of vital importance to every practitioner. This organization meeting is one he should attend, that he cast his vote in the correct direction and for that leader who will once again make general practice highly respected.

In keeping with the plan to raise the quality of general

practice Harry E. Bacon of Philadelphia has been secured to lecture on "Office Procedures in Proctology". A dinner will precede the meeting and all those who plan to attend should send \$1.00 to the secretary, Herman S. Cutler, 425 Forbes Avenue, New Haven.

NEW ENGLAND SECTIONAL MEETING AMERICAN COLLEGE OF PHYSICIANS

Preliminary plans for the New England Sectional Meeting of the American College of Physicians to be held at Providence, R. I., on Wednesday, January 14, 1942, have been announced by Alex M. Burgess, Rhode Island Governor of the College. In the morning from 10 until 12, clinical sessions will be held at the Peter's House at Rhode Island Hospital under the supervision of Charles F. Gormly, general chairman of the local group planning the meeting, and at noon luncheon will be served at the hospital.

The afternoon will be devoted to scientific discussions at the auditorium of the Rhode Island Medical Library, with the presentation of papers by outstanding members of the College in New England from 2 to 5 P. M. The day's program will be concluded with a dinner at the Squantum Club at 6:30 P. M.

The local committee in charge of the meeting, in addition to A. M. Burgess and C. F. Gormly, includes William S. Streker, Elihu S. Wing, and John F. Kenney.

CONVALESCENT COTTAGE AT THE CHILDREN'S CENTER

On Wednesday, November 12, The Children's Center at 1400 Whitney Avenue, New Haven, opened a recently developed cottage for convalescent care. They are prepared to accept any child between the ages of four and sixteen years from any part of Connecticut for convalescent care, providing the child is not suffering from a contagious disease. The Cottage is built to house forty one children, and the rate for care, which included all clothing and other necessities during the child's stay at the cottage, is \$16.00 per week.

A New Haven school teacher is in charge of the class room. There is also a trained occupational therapist, as well as a physiotherapist on the cottage staff. A registered trained nurse is in charge. She is assisted by a night nurse and four registered trained attendants.

A resident pediatric intern is constantly in attendance and daily personal supervision is given by three well established practicing New Haven pediatricians. Doctors from all branches of medicine are available for consultation at any time. The medical policies and set up are maintained by a competent medical committee of which Joseph I. Linde is chairman.

FELLOWSHIPS IN NUTRITION

Effective November 1, 1941, Swift & Company will make available a limited number of fellowships to universities and medical schools, for research in nutrition.

To be eligible for grants, projects should be aimed at one of the following objectives:

1. The development of fundamental information on the nutritive properties of foods.
2. The application of this fundamental information on the nutritive properties of foods to the improvement of the American diet and health.

Swift & Company is naturally interested in nutrition research on meat and meat products, but grants will not be strictly limited to work in these fields. Any worthwhile study on the nutritive properties of foods or the improvement of diets will be eligible for a grant.

Each fellowship will be operative for one year, unless renewed, and will be granted in an amount to be determined by the scope of the project. Placement of the Fellowships in Nutrition will be coördinated by Doctor R. C. Newton and his staff of the Research Laboratories of Swift & Company, Union Stock Yards, Chicago.

Urology Award

The American Urological Association offers an annual award "not to exceed \$500.00" for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years.

Essays shall be in the hands of the Secretary, Doctor Clyde L. Deming, 789 Howard Avenue, New Haven, Conn., on or before April 1, 1942.

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OBITUARIES

Max Mailhouse, M.D.

1857 - 1941

Max Mailhouse died at his home in New Haven on October 19, 1941, of an acute coronary occlusion. He had seen his last patient on the very day of his death, terminating 63 years of medical practice in New Haven.

Born in New Haven, February 5, 1857, Doctor Mailhouse was the son of the late Jacob and Caroline Rosenthal Mailhouse. He studied in the public schools and was graduated from Yale University in the class of 1876, Sheffield Scientific School, and in 1878 from the School of Medicine.

He began practice in New Haven immediately after graduation and was a highly respected and busy general practitioner for many years. In the early years of the 20th century he developed a special interest in neurology and studied in New York City with the leaders of that branch of his profession. He soon became one of the outstanding neurologists in Connecticut and throughout his lifetime his consulting practice covered all parts of the State.

He was clinical professor of neurology at Yale from 1907 to 1920 and until his death held the title of professor emeritus in that department. He was consulting neurologist on the staffs of numerous hospitals in various Connecticut cities.

Doctor Mailhouse was a member of the Connecticut State Medical Society since 1878, a record shared at the time of his death with Doctor Bull of Plainville. He served as president of the Society for the year 1915-1916, and was president of the National Association for the Study of Epilepsy for the year 1906-1907. He also was a member of the Connecticut Society for Psychiatry and Neurology, New York Neurological Society, American Medical Association, Association for Research in Nervous and Mental Disease, American Psychiatric Association, and the International Association for the Study of Epilepsy.

When, in 1893, the State of Connecticut inaugurated legislation regulating the practice of medicine, Doctor Mailhouse was in a considerable degree responsible for the state law, and he became

the secretary of the first State Medical Examining Board. In this capacity he served from 1893 to 1900.

He was president of the Yale Class Secretaries' Association from 1916 to 1917 and was a member of the Yale Alumni Advisory Board. From 1917 to 1918 he was a member of the examining board for officers of the Medical Reserve Corps.

His civic interests led him along practical lines and were fostered by his interest in the welfare of his patients. As an example, Doctor Mailhouse was the chief sponsor of an anti-noise campaign in New Haven and was chairman of an Anti-noise Commission appointed by the Mayor in 1937.

His first wife, the former Clara Johnson, died in 1900. Two years later he married Celia Katz who died in 1912. In his household at the time of his death were his son, a sister and a niece. Surviving him also are three married daughters and several grandchildren.

Doctor Mailhouse was respected by his colleagues and his patients throughout the state for his thoroughness, honesty, and clinical judgment. He was honored as a leader for the constructive efforts he had always put forth for the greater welfare of the physicians and his patients. He was cherished and remembered by all who met him for his friendly manner and his never failing good humor.

Bernhard A. Rogowski, M.D.

John Purney, M.D.

1878 - 1941

John Purney was born in Shelburne, Nova Scotia, in the year 1878. He began his professional career as a school teacher but soon decided to become a physician. He attended Baltimore Medical College and was graduated in 1906. Doctor Purney's first office was in North Manchester, Connecticut, but it was not long before he moved to New Britain.

During World War I he served as a Captain in the Canadian Expeditionary Force. At home in New Britain he was for many years Medical Examiner. He served as Attending Physician on the New Britain General Hospital Staff from 1911 until the day of his death, July 18, 1941.

His memory is best honored where it lies, deeply enshrined in the hearts of his many devoted patients.

His associates remember him as a man of great personal charm and simple sincerity of manner. Throughout a full and intensively active profes-

sional life his record was exemplary. Words cannot add to his already great stature.

But in remembering a doctor let us not forget a man. John Purney was of the best. His innate kindness was never better shown than by the fact that daily throughout a busy career he could find time to feed the squirrels who awaited him in Walnut Park, and the pigeons who swarmed about him every morning at the hospital. Nor will anyone forget his appearance each Christmas morning; radiant with happiness and engulfed in a great load of presents which he distributed with lavish hand. His greatest joy was in giving.

In the death of John Purney we have suffered irreparable loss.

Richard W. Pullen, M.D.

Edgar Mayer Johnson, M.D.

1887 - 1941

Edgar Mayer Johnson died suddenly at his home, 73 Howe Street, New Haven, of a coronary thrombosis. He was born July 4, 1887, at Cincinnati, Ohio.

Doctor Johnson prepared for college at the Culver Military School and Betts Preparatory School, and graduated from Yale with the Class of 1908. The following two years were spent in the employment of the Austro-American Steamship Company. He then entered the School of Medicine, Yale University, and graduated in 1914, being the secretary of his class. He served an internship at the Lenox Hospital, New York, and then spent several years at the New Haven Hospital, being the first resident in the isolation building. He married Margaret McCarthy of New London, July 18, 1918, and practiced medicine in New Haven since that time.

Doctor Johnson was president of Phi Gamma Delta Society. He also belonged to Nu Sigma Nu, the Graduate Club, and the Trumbull Lodge of the Masonic Order. He was chairman of the House Committee of the New Haven Medical Society and a member of the New Haven County and State Medical Societies. He was examiner for Draft Board 9B. For the past few years he specialized in Heart Disease, taking courses in New York and Boston. He developed a wide consultation practice in a very short time and seemed assured of success in this field.

Doctor Johnson, or "Johnny" as he was known to his many friends, possessed a very friendly nature and was a man of becoming modesty, with great

sincerity and loyalty. He performed all his duties faithfully and well.

T. J. Sullivan, M.D.

OUR NEIGHBORS

New Jersey

The Medical Society of New Jersey has just concluded its largest single public relations project in which members of the Society addressed 84 different Kiwanis Clubs throughout the state. The talks were focused on the topic, "The American Way of Distributing Medical Care." The job of preparing scripts, selecting speakers, assigning the talks, securing the publicity, adjusting calendar conflicts, taking care of last minute changes and furnishing factual material to the speakers was a huge one and was made possible by effective team work between the public relations committee of the State Society and the corresponding committees of the county organizations. New Jersey reports gratifying results.

Vermont

At the 127th annual meeting of the Vermont State Medical Society held in Burlington, October 2 and 3, Roland E. McSweeney of Brattleboro was chosen president-elect and Ernest H. Buttles of Burlington, president. Benjamin F. Cook of Rutland was re-elected secretary. Albert M. Cram of Bridgewater, in his retiring presidential address, discussed "Early Medical Education in Vermont."

Connecticut Tuberculosis Association

The Second Annual Meeting of the Connecticut Tuberculosis Association was held on October 22 at Hartford. Doctor David R. Lyman, the first president, spoke informally. Doctor Paul S. Phelps, director of case finding, State Tuberculosis Commission, and Doctor H. E. Kleinschmidt of the National Tuberculosis Association presented a paper on "Tuberculosis and National Defense."

Professor Hiscock of Yale University Department of Public Health was re-elected president of the Association and Doctor Joseph I. Linde of New Haven was elected a vice-president. Doctor Lyman is a member of the executive committee.

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NEW BOOKS IN REVIEW

EXPECTANT MOTHERHOOD. By Nicholas J. Eastman, M.D., Professor of Obstetrics at Johns Hopkins University and Obstetrician in Chief to the Johns Hopkins Hospital. Boston: Little Brown & Co. 1941. 176 pp. \$1.25.

Reviewed by STANLEY B. WELD

The expectant mother of this enlightened age quite often requests of her obstetrician the name of some handy reference book to be used as a guide during the nine months. Such obstetrical guide books written prior to the last decade are outmoded, in fact, it is only in the latest publications of this sort that one may find answers to many of the questions which arise in the mind of the modern expectant mother. Perhaps one of the most important functions of such a book is to dispel the fears due to superstitions as well as those provoked by a gossiping neighbor.

Doctor Eastman has covered the subject carefully. His remarks on bridge-table obstetrics, and on home versus hospital delivery are sagacious, while the chapter on Painless Childbirth is phrased in an extremely clear and helpful manner. A short chapter on The Newborn Baby is added to assist the mother while convalescing from her labor.

Nine illustrations are included in this volume, some of questionable value to the uninitiated. It is a book which should be used to supplement the advice of the patient's own obstetrician and as such may be of considerable value to both doctor and patient.

HANDBOOK OF COMMUNICABLE DISEASES. By Franklin H. Top, A.B., M.D., M.P.H., Director, Division of Communicable Diseases and Epidemiology, Herman Kiefer Hospital and Detroit Department of Health; Wayne University, College of Medicine, and Collaborators. St. Louis: C. V. Mosby Company. 1941. 682 pp. 73 illustrations and 10 color plates. \$7.50.

Reviewed by C. L. THENEBE

There are 46 chapters which comprise this book. These cover the general subjects of Infection and Immunity, Epidemiology, Regulations Governing Control of Communicable Disease, Specific Prevention of Certain Communicable Diseases, Serum and Serum Reactions, Management of Communicable Diseases in the Home and in the Hospital, as well as chapters on all the more common communicable diseases.

Doctor Top's book is a somewhat condensed but a complete, straightforward and very effectual exposition of communicable diseases. There is neither a dull nor a weak chapter in it. This volume is the answer to those wishing a distinctive book which adequately deals with communicable diseases. It is a truly superior handbook of transmissible diseases for all physicians and well informed nurses.

X-RAY TREATMENT OF CHRONIC ARTHRITIS. By Karl Goldhamer, M.D., Associate Director, Quincy X-ray and Radium Laboratories; Associate Roentgenologist, St. Mary's Hospital of Quincy; Formerly Roentgenologist, University of Vienna. *Quincy, Illinois: Radiologic Review Publishing Co.* 1941. 131 pp. Illustrated. \$2.00.

Reviewed by RALPH T. OGDEN

This monograph is a preliminary report of one hundred consecutive patients suffering with chronic arthritis, treated with x-ray during the past two years by the author. It was written primarily to stimulate the interest of the general practitioners in this type of therapy, and is from a practical point of view more than from a scientific one.

A large part of the book is devoted to x-ray diagnosis with excellent drawings for demonstrations rather than reproductions of roentgenograms. Some attention is given to indications and contraindications of treatment, clinical aspects of chronic arthritis, history and pathology. The therapeutic portion of the book is a little premature as it is based on too few cases observed over too short a time. This, however, is somewhat compensated for by the enthusiasm of the writer and a past experience of some twenty years with x-ray therapy of arthritis before coming to this country.

There are 131 pages well written and easy to read and in view of the recent tendency in this country to treat some of these chronic arthritics with x-ray the book should be interesting and helpful to all physicians who have occasion to see and treat these cases.

NECROPSY—A Guide for Students of Anatomic Pathology. By Béla Halpert, M.D., Ass'tant Professor of Pathology and Bacteriology, Louisiana State University School of Medicine, and Visiting Pathologist, Charity Hospital of Louisiana at New Orleans. *St. Louis: The C. V. Mosby Company.* 1941. 72 pp. \$1.50.

Reviewed by RONALD S. BECKETT

Doctor Halpert presents a small epitome of the post mortem examination. We suggest that an alternative title might be "Things Not to Forget and Places not to Overlook at the Autopsy Table."

The book is actually an exposition of a method of removal and examination of the human organs originally published by Anton Ghon of Prague, and sponsored by the author in the United States. The procedure proposed is threefold. First, the organs are exposed *in situ* and examined with original relationships preserved; second, they are removed by systems; and third, they are examined separately, opened, and sectioned. Complete instructions in the technic of the second stage are provided. The text of stages one and three consists of lists of structures to be "inspected"; they are long lines of anatomical nouns, supported only by such destructive verbs as "cut", "slice", "reflect", or "strip". Such matters do not make the most fascinating reading, but the anatomical lists are fairly complete. A modification of procedure for the examination of newborn subjects is provided.

References to actual gross pathological findings are sparse



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and terse; they consist of an occasional, parenthetical word or phrase, during the discussion of an organ or structure. This restraint has spared the author the disgrace of producing a hybrid essay on gross pathology.

At the end of the text there is an appendix, consisting of two sample protocols, with clinical history, laboratory findings, and gross description according to the Ghon method, with microscopic analyses and the anatomical diagnoses deduced therefrom.

This work succeeds in presenting a sequential method for performing an autopsy, and in this role may be of some aid to the occasional post mortem examiner, or to the novice. As one method, it is applicable to the "ordinary" autopsy, but since the "ordinary" autopsy is as rare a bird as the "average" human, the system can serve only as a dismembered skeleton which the pathologist, if he would use it, must assemble in many ways.

On page 34 the author directs that the lung, after removal from the body, be opened by a single incision "in the center of the costal surface from apex to base toward the hilus, and when indicated additional parallel incisions may be made". The reviewer feels very strongly that such an examination of lung will leave hidden pulmonary features that are far larger and more important than Ghon foci.

THE 1941 YEAR BOOK OF RADIOLOGY. By Charles A. Waters, Associate in Roentgenology, Johns Hopkins University, and Ira I. Kaplan, Director, Radiation Therapy Department, Bellevue Hospital, New York City. Chicago: The Year Book Publishers, Inc. 1941. 426 pp. \$5.00.

Reviewed by WENDELL C. HALL

The 1941 Year Book of Radiology, as in previous years, is divided about equally between diagnosis and therapy. As a result of the war there has been a relative scarcity of foreign publications on radiological subjects during the past year. In spite of this fact, however, approximately one-fourth of the articles in the year book came from outside the U. S. A. Eighty journals are represented and 327 well illustrated articles are reviewed in the book. Due to the international situation a section on military roentgenology has been included this year.

The usual high state of excellency in the present year book

has been maintained by the same editors as in previous years. This book should again be of interest, not only to the radiologist, but also to the general practitioner as well as to other specialists.

CLINICAL IMMUNOLOGY, BIOTHERAPY AND CHEMOTHERAPY IN THE DIAGNOSIS, PREVENTION AND TREATMENT OF DISEASE. By John A. Kolmer, Professor of Medicine, Temple University School of Medicine, Director of the Research Institute of Cutaneous Medicine; and Louis Tuft, Assistant Professor of Medicine and Chief of Clinic of Allergy and Applied Immunology, Temple University School of Medicine. Philadelphia: W. B. Saunders Company. 941 pp. Illustrated. \$10.00.

Reviewed by WILSON FITCH SMITH.

As this rather formidable title suggests, this book is an omnibus containing the recent knowledge in the fields of immunology, biotherapy and chemotherapy which are powerful allied forces employed by the modern clinician in the diagnosis, prevention and treatment of disease. The material is presented in two parts. Part one contains the theoretical background and includes the general aspects and fundamentals, the understanding of which is important in the proper selection and application of the available agents. Each type of therapy is discussed in its general relation to the various types of disease. In the second part, however, each disease or infection is presented separately with the different methods of combating it discussed at the time. This is the practical part of the text that gives the actual clinical applications of the sciences presented in the first part.

The text is quite up to date, containing, for instance, information about the more recent chemotherapeutic agents, sulfadiazine and sulfaguanidine. Much of the experimental data, however, seems based on sulfanilamide and sulfapyridine. In fact, in the table of toxic manifestations of the sulfonamide drugs, none of the reactions to sulfathiazole are mentioned.

There are many excellent tables that are useful for quick reference, and particularly handy for the hurried clinician are the splendid summaries at the end of each chapter in Part I and after each disease mentioned in Part II. Selective

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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bibliographies appearing after each discussion are available for those who wish to read further in the subject.

Many should be able to benefit from this interesting grouping of subjects which are often treated separately, but which logically belong under the same cover. The book was primarily prepared, as the authors state in their preface, "from the clinical or practical standpoint for practitioners of medicine and public health," but it should also have a very valuable place in the library of medical students and their teachers as well.

DISEASES OF WOMEN. (9th edition.) By Harry Sturges Crossen, M.D., F.A.C.S., Professor Emeritus of Clinical Gynecology, Washington University School of Medicine and Robert James Crossen, A.B., M.D., Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine. St. Louis: C. V. Mosby Co. 1941. 948 pp. 1127 engravings. \$12.50.

Reviewed by STANLEY B. WELD

The active life of this work so far covers a period of more than thirty years, the first edition appearing in 1907. With each new addition, new subjects have been added or further elucidated so that this latest edition contains the recent

knowledge of ovarian and uterine physiology and the action of the hormones. The arrangement of the text has been carried out as before with a view to presenting points of importance clearly and systematically. A large portion of the volume is utilized in affording the reader a variety of excellent illustrations, including many in color.

This volume contains many of the more recent procedures described in detail. Tubal insufflation tests are dealt with quite fully, there is a limited amount of information on the vitamins, sulfonamide therapy in acute gonorrhea is covered carefully, and the use of the Miller-Abbott tube in the complications of postoperative care is explained. The authors have not cleared up the old confusion centering around the terms hyperplasia of the endometrium and chronic endometritis, nor do we find mention made of non specific urethritis, nor of the syndrome of hydrothorax, hydroperitonum, and fibroma of the ovary. Our own Doctor Emerson L. Stone of New Haven is quoted for his results in successfully treating dysmenorrhea with dilation of the cervix but this procedure is overshadowed by the questionable use of stem pessaries where more permanent results are desired.

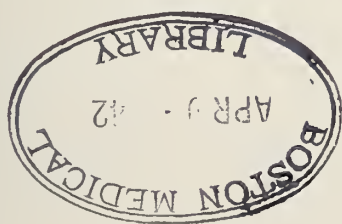
As a reference volume for the general practitioner and a text for the medical student this book may be recommended. It should take its place in the gynecologist's library along with many other similar texts and volumes of more limited scope.

The Connecticut State Medical Journal

. . INDEX . .

Volume V

January - December, 1941



A

A New Leader (Ed.)	vii 517
A Real Honor (Ed.)	vi 440
A Tout Seigneur Tout Honneur (Ed.)	xi 837
A Word of Caution (Ed.)	xii 909
Academy of Pediatrics Meeting in New Haven (Ed.)	iii 211
Acute Aleukemic Leukemia (Crane)	ix 673
Advances With Full-Time Health Leadership: Progress Reported in Middletown (Foote)	ii 116
A Family History Influences Treatment and Prevention (Burns)	iii 207
Amelanotic Melanoma (Case Report)	iii 193
America Needs a Credo (Ed.)	ii 122
American Medical Association in Cleveland	vii 525
An Editorial by the President (Gold)	x 765
Anesthetic Control of Abdomen (Rovenstine)	ii 88
Annual Physical Examination (Ed.)	v 351
Annual Reports, Conn. State Medical Society	v 373; vi 465; vii 541
Annual Secretaries Conference at Chicago	xii 915
Another Clinical Congress (Ed.)	vii 520
Appendicitis Syndrome Due to Allergy, The (Lieberman)	iv 277
Aspects of Medical Defense in England (Fulton)	i 10
Aspects of the Narcotic Problem (Foster)	iii 183
Association of Connecticut Tumor Clinics:	
Eighteenth Meeting, Bridgeport	iii 197
Nineteenth Meeting, Middletown	x 744
Avertin in Treatment of Tetanus (Brody)	xii 896

B

Background of Public Health in Connecticut (Hiscock)	xi 821
Belladonna Root Treatment of Chronic Encephalitis (Gold)	xi 811
Bellum and Cerebellum (Burlingame)	ii 83

C

Cancer of the Colon in Twins (Coll and Humphrey)	iv 279
Cancer and the Women's Field Army (Ed.)	iii 210
Carcinoma of the Duodenum (Cressy)	xi 818
Case of Wandering Spleen With Torsion of the Pedicle Simulating a Pelvic Tumor (Lahn)	iv 274
Causes of Death in Connecticut (Ed.)	viii 575
Certification Under Fire (Ed.)	viii 574
Chairman of Council Honored (Ed.)	xii 911
Chemotherapy in Pelvic Inflammatory Disease (Studdiford)	xi 799
Citizenship—Licensure (Ed.)	i 53
Clinical Congress, 1941, The (Nahum)	ix 644
Clinical Congress, 17, Excels (Ed.)	xi 836
Clinical Congress, 17, Program of	vii 513; ix 635
Clinical Consultations and Hospital Care Services in a Maternal and Child Health Program (Clifford)	vii 510
Clinical Interpretation of Blood Iodine Levels (Riggs, Gildea and Man)	iii 209
Commendation Appreciated (Ed.)	vi 441
Compulsory Health Insurance (Ed.)	v 349
Congenital Urological Anomalies (Nueswanger)	ix 671

Connecticut Again Leads (Ed.)	vii 517
Connecticut Clinical Congress, 1941	xi 811
Connecticut Doctors in Other Fields (Thoms)	v 337
Connecticut Hospital Association	i 58; ii 130; iii 211; iv 291; v 355; vi 445; vii 528; viii 579; ix 697; x 772; xi 841; xii 918
Connecticut Looks at Smallpox—Then and Now (Knowlton)	i 13
Connecticut Medical Bibliography (Steiner)	iv 248
Connecticut Pediatric Consulting Service, The (Clifford)	iv 280
Connecticut Plan For Hospital Care, After Four Years, The (Ed.)	ii 124
Connecticut Selective Service	iii 221
Connecticut's Part in the Development of Psychiatry in America (Burlingame)	x 727
Conservative Treatment in Fractures of the Neck of the Humerus (Moorhead) (Abstracted)	iv 267
Crippled Children in Connecticut (Spekter)	x 755

D

Danbury Honors David Chester Brown	vii 521
Depressive Reactions in Middle Aged Men (Terhune)	ii 104
Dermatitis Caused by Nylon Stockings (Gipstein)	iv 278
Diagnosis by Gastroscopy (Kushlan)	ix 665
Diagnosis of Cancer of the Stomach and Colon (Oughterson)	vii 506
Diet and Bright's Disease (Weiss)	vii 496
Differential Diagnosis of Low Back Pain (Swett)	v 330
Discussion of Symposium on Gastro-Enterology (Miller)	ix 669
Doctor Edgar A. Hines (Ed.)	ii 126
Doctor in the Navy (White, Capt. M.C.)	xii 922
Doctor Klumpp Goes to A. M. A. (Ed.)	vii 520
Doctor Linde Reappointed to Tuberculosis Commission (Ed.)	viii 576
Doctor's Office, The	ii 137; iii 223; v 369; vii 544; viii 578
Doctor Osborn Succeeds Himself (Ed.)	vii 518
Doctor Sigerist Prescribes (Ed.)	iv 287
Doctor Samuel Holden Parsons Lee: His Life and Times (Labensky)	ii 92
Doctors and the Law (Ed.)	xii 908

E

Eagle and Its Prey, The (Ed.)	v 350
Early Medical Practice in Hartford County (Weld)	vii 484
Evaluation Studies of Laboratories Performing Serodiagnostic Tests for Syphilis (Mickle and Borman)	vi 434

F

Foreign Graduate, The (Ed.)	vi 441
Forum, The	i 65; ii 153; iii 223; iv 304; v 368; vi 472; vii 545; viii 590; ix 711; x 789; xi 857; xii 936
Founding of the New Haven County Medical Association (Barker)	iii 180
From the Secretary's Office	i 55; ii 127; iii 212; iv 289; v 353; vi 442; vii 523; viii 577; ix 694; x 771; xi 838; xii 912
Function of the Bile with Special Reference to Therapeutic Use of Bile Salts (Greene)	xi 804

G

Gastro-Intestinal Disturbances in Nervous and Mental Disorders (White)	vi 425
Gastro-Intestinal Symptoms in Eye, Ear, Nose and Throat Disorders (Baron)	vii 502
General Practitioners' Section, The (Ed.)	v 349
General Practitioners' Section (See The Forum)	
Good Blood (Ed.)	v 352
Graves, James Chapman (Obit.)	v 398
Gray, William Henry (Obit.)	xi 860

H

Have Adults Adopted the Tablet Form of Diet (Nickerson)	i 45
Hawaii Medical Journal, Vol. 1, No. 1 (Ed.)	xii 911
Health Here and In Europe (Ed.)	iv 287
Help Conserve Hearing (Davis)	x 754
How To Overcome the Smoking Habit (Kahn and Gildea)	886
Hubbard, E. Kent (Ed.)	ix 693
Hypernephroma With Metastases to Scapula (Tylec)	vi 432

I

Indications for Therapeutic Use of Amino Acids (Farr)	i 24
Industrial Health	vi 461; vii 538; viii 591; ix 705; xi 853; xii 932
Industrial Medicine (Landry)	vii 481
Insurance Premiums in War Emergency (Ed.)	i 50
Iontophoresis with Zinc Peroxide in the Treatment of Indolent Ulcers (Gurewitsch)	ix 664

J

Johnson, Edgar Mayer (Obit.)	xii 943
------------------------------	---------

L

Large Bowel Cancer—Symposium from 16th Clinical Congress (Oughterson)	xii 890
Legislative Section (See Public Affairs)	
Legislature (See Public Affairs)	
Letters to the Editor	iv 305; v 399; viii 595; ix 713
Lindsay, John Crandall (Obit.)	i 70
Line Forms on the Left, The (Ed.)	ix 692
Liquor and Hats (Ed.)	viii 575
Lost Art of Prescription Writing, The (Ed.)	i 52
Low Temperature Therapy of Malignancy (Herrmann)	x 721

M

Maher, Thomas Francis (Obit.)	v 399
Mailhouse, Max (Obit.)	xii 942
Mallory, Frank Burr (Ed.)	xi 837
Maternal Mortality in Connecticut (Howard)	ix 646
May, George William (Obit.)	iii 235
Mead, Kate Campbell (Obit.)	ii 158
Medical Care for the Underprivileged (Winslow)	i 7
Medical Preparedness Section	iii 218; iv 296; v 360; vi 450; vii 532; viii 584; ix 700; x 778; xi 846; xii 922
Doctor in the Navy (White, Capt., M.C.)	xii 922
Miscellaneous	ii 138
Organization of General Hospital No. 39 (Fox, Jr.)	i 61
Planning for a Pandemic of Influenza (Knowlton)	ii 140
Station Hospital, U. S. Army Air Base, Windsor Locks	xii 923

Medical Student and the Draft (Ed.)	xii 910
Medicine and the Antitrust Act (Hamilton)	xii 873
Meet the Bride and Groom (Ed.)	x 765
Message From the President (Gold)	vi 439
Midwinter Dinner of State Medical Association (Ed.)	ii 125
Miscellaneous	ii 138
Mortality in Diabetic Coma (Labensky)	xii 898
Multiple Aneurysms of Splenic, Gastric, Renal, and Superior Mesenteric Arteries (Levy)	viii 567
Murphy, Bernard Patrick (Obit.)	viii 595

N

National Physicians Committee After the Election (Ed.)	i 54
National Physicians Committee in 1941, The (Ed.)	ix 693
Necessity for Recto-Sigmoidal Examination (Kleiner)	ix 667
Neurologic Lesions That Give Symptoms (Fox, Jr.)	vi 429
New Books in Review	i 71; ii 159; iii 238; iv 313 v 401; vi 478; vii 550; viii 596; ix 714; x 795; xi 864; xii 944
New School of Nursing, The (Ed.)	x 767
New Superintendent at Mansfield (Ed.)	xii 910
New Yale Library, The (Thoms)	ix 689
New Zealand Experiment (Ed.)	xi 836
Newer Insulins, The (Greenhouse)	iii 189
News From County Associations	i 63; ii 154; iii 233; iv 306; v 369; vi 473; vii 543; viii 593; ix 709; x 793; xi 857; xii 937
News From Yale University School of Medicine	ii 156; iii 234; iv 309; v 372; viii 594; ix 711; xi 859
Non-Repetative (Ed.)	iii 211

O

OCD—The Latest in Defense Planning (Ed.)	x 769
Observations Upon the Simpler Technique in Scarlet Fever Immunization (Thenebe)	x 737
On the Nature and Treatment of Epilepsy (Putnam)	iv 257
Organization of General Hospital No. 39 (Fox, Jr.)	i 61
Organizing Your Town For Health (Ed.)	ii 124
Origin of Connecticut State Medical Society (Barker)	xii 900
Osborne, Oliver Thomas (Obit.)	i 68
Osteogenic Sarcoma (Walker)	i 43
Our Neighbors	ii 137; v 368; vi 469; vii 543; viii 593; ix 709; x 791; xii 943
Outerson, Richard Ambrose (Obit.)	v 398

P

Patient's Dilemma, The (Ed.)	xi 834
Peptic Ulcer Today (Ed.)	xii 908
Physical Status of American Young Men (Perrott)	xi 817
Physiological Effect of Cold, The (Barbour)	x 719
Planning for a Pandemic of Influenza (Knowlton)	ii 140
Preliminary Program for 149th Annual Meeting	iv 282
Prenatal Blood Test Law (Ed.)	vii 519
Preparedness Program Today, The (Barker)	i 36
Principals and Recommendations of Joint Conference Committee	xi 862
Problem of Gastric Ulcer (Jordan)	vii 879
Program for 149th Annual Meeting	v 321
Progress by Metamorphosis (Ed.)	iii 210
Progress Report on Experiment in Control of Cancer of the Uterus (Macfarlane)	xi 814
Psychiatric Considerations in Selection of Military Personnel (Cohen)	vi 453

Psychiatric Contraindications to Marriage (Kahn)	ix 684
Puberty, Adolescence and the Pediatricist (Ed.)	v 352
Public Affairs	ii 152; iii 225; iv 300; v 363; vi 458; vii 535; viii 587; ix 703; x 781; xi 850; xii 930
Purney, John (Obit.)	xii 942

Q

Quarto Notes (See New Books in Review)	
Quo Vadis? (Ed.)	viii 573

R

Relation of the Doctor to the Hospital (Miller)	iii 165
Remarks on Efficient Traction (Wellington)	iii 170
Rheumatic Fever in Connecticut (Ed.)	viii 575
Rheumatic Heart Disease (Yeager)	i 19
Root, Stella Quimby (Obit.)	vi 469
Roster of Members	viii 597
Rupture of Uterus (Berlowe)	ii 97
Ryan, Timothy Maher (Obit.)	vi 469

S

S. B. 529 (Ed.)	iv 286
Scarlet Fever Immunization (Thompson)	x 736
Section on General Medicine (Ed.)	xii 911
Simultaneous Occurrence of Herpes Zoster and Varicella (Ward)	i 41
Slaughter, William H. (Obit.)	viii 596
Small Dust of the Balance, The (Ed.)	xi 834
Socialized Osteopathy (Ed.)	xi 835
Some Clinical Oversights of Significance (Backer)	x 741
Some Early Medical Teachers in Connecticut (Ferris)	vi 411
Some Economic Problems By a Non-Professing Economist (Lahey)	iii 173
Some Observations on the Management of Acute Obstruction in the Small Intestine (Ed.)	ii 123
Some Remarks on "Cases and Observations: By the Medical Society of New Haven County" (Blumer)	ix 652
State Aid to Blind in Connecticut (Blake)	ii 110
State Department of Health:	
A Family History Influences Treatment and Prevention (Burns)	iii 207
Advances With Full-Time Health Leadership: Progress Reported in Middletown (Foote)	ii 116
Clinical Consultations and Hospital Care Services in a Maternal and Child Health Program (Clifford)	vii 510
Clinical Interpretation of Blood Iodine Levels (Riggs, Gildea and Man)	iii 209
Connecticut Pediatric Consulting Service, The (Clifford)	iv 280
Crippled Children in Connecticut (Spekter)	x 755
Evaluation Studies of Laboratories Performing Serodiagnostic Tests for Syphilis (Mickle and Borman)	vi 434
Have Adults Adopted the Tablet Form of Diet (Nickerson)	i 45
Swimming Places and Public Health (Scott)	viii 570

Station Hospital, U. S. Army Air Base, Windsor Locks (Woodward, Lt. Col., Air Corps)	xii 923
Stiles, Charles Wardell (Obit.)	iv 313
Sulfathiazole Treatment of Gonococcal Infections in Ambulatory Patients (Celentano and Lewis)	v 344
Survey of the Anesthesia Service at Grasslands Hospital 1938 to 1940 (Bishop)	iv 270
Swimming Places and Public Health (Scott)	viii 570
Symptoms Compelling Attention to the Heart (Nahum and Piccolo)	iv 261
Synovial Sarcoma (Leichner and Schaefer)	ii 113

T

The Doctors Welch of Norfolk (Cushing) (Reprinted)	viii 557
Thrombophlebitis; With Particular Reference to Treatment (Mahorner)	iv 243
Treatment of Coronary Disease (Blumgart) (Abstracted)	ii 102
Treatment of Prostatic Hypertrophy with Sex Hormones (Ed.)	x 766
Trigeminal Neuralgia (Ed.)	iv 286
Tularemia in Connecticut (Gibbons, Lamoureux and Arkless)	ix 679

U

Unusual Case of Hodgkin's Disease (Finkelstein)	ix 687
Use and Abuse of Physical Agents in Treatment of Chronic Arthritis (Osgood)	i 28

V

Vitamins—The Need for a Proper Perspective (Ed.)	i 51
Vocational Rehabilitation of the Disabled Connecticut Worker (Chester)	iii 191

W

Warren Prize Comes to Connecticut, The (Ed.)	iv 285
Watch the National Physicians Committee (Ed.)	iv 288
Weather and the Practice of Medicine (Petersen)	vi 405
"We'd Rather Be Bombed Than Bored:" A Personal Interview	xii 927
Welcome to Bridgeport	v 347
Were You There? (Ed.)	vi 440
What Can We Learn from Gastroscopy (Flexner)	xii 889
What Is The Solution (Ed.)	i 53
Who Cares About the Mental Patient? (Ed.)	xii 909
Why Exhume the Midwife? (Ed.)	x 768
William Beaumont (Chittenden) (Reprinted)	viii 561
Woodruff, Thomas Adams (Obit.)	vii 546
Woodson, J. Tyree (Obit.)	iii 235

X

X-ray Examination of 8210 Selectees at Induction Center, Hartford (Phelps and Green)	xii 882
--	---------

Y

Yale Dedicates New Medical Library	vii 522
------------------------------------	---------

. . INDEX . .

Volume V

January - December, 1941

A		Chittenden, Russell H.	
Arkless, Henry A. (with Gibbons and Lamoureux)		William Beaumont	viii 561
Tularemia in Connecticut	ix 679	Clifford, Martha L.	
B		Clinical Consultations and Hospital Care Services in	
Backer, Marcus		a Maternal and Child Health Program	vii 510
Some Clinical Oversights of Significance	x 741	The Connecticut Pediatric Consulting Service	iv 28
Barbour, Henry C.		Cohen, Louis H.	
The Physiological Effect of Cold	x 719	Psychiatric Considerations in Selection of Military	
Barker, Creighton		Personnel	vi 453
Founding of the New Haven County Medical		Coll, J. (with Humphrey)	
Association	iii 180	Cancer of the Colon in Twins	iv 279
The Preparedness Program Today	i 36	Crane, J. E.	
Origin of Connecticut State Medical Society	xii 900	Acute Aleukemic Leukemia	ix 673
Baron, Shirley Harold		Cressy, Norman L.	
Gastro-Intestinal Symptoms in Eye, Ear, Nose and		Carcinoma of the Duodenum)	xi 818
Throat Disorders	vii 502	Cushing, Harvey C.	
Berlowe, Max L.		The Doctors Welch of Norfolk	viii 557
Rupture of the Uterus	ii 97	D	
Bishop, Harold F.		Davis, James E.	
Survey of the Anesthesia Service at Grasslands Hos-		Help Conserve Hearing	x 754
pital 1938 to 1940	iv 270	F	
Blake, Eugene M.		Farr, Lee E.	
State Aid to Blind in Connecticut	ii 110	Indications for Therapeutic Use of Amino Acids	i 24
Blumer, George		Ferris, H. B.	
Some Remarks on "Cases and Observations: By the		Some Early Medical Teachers in Connecticut	vi 411
Medical Society of New Haven County"	ix 652	Finklestein, William	
Blumgart, Herrman L.		Unusual Case of Hodgkin's Disease	ix 687
Treatment of Coronary Disease	ii 102	Flexner, James	
Borman, Earle K. (with Mickle)		What We Can Learn From Gastroscopy	xii 889
Evaluation Studies of Laboratories Performing Sero-		Foote, Franklin M.	
diagnostic Tests for Syphilis	vi 435	Advances With Full Time Health Leadership:	
Brody, Bernard S.		Progress Reported in Middletown	ii 116
Avertin in Treatment of Tetanus	xii 896	Foster, John H.	
Burlingame, C. C.		Aspects of the Narcotic Problem	iii 183
Bellum and Cerebellum	ii 83	Fox, James C., Jr.	
Connecticut's Part in the Development of Psychiatry		Organization of General Hospital No. 39	i 61
in America	x 727	Neurologic Lesions That Give Gastric Symptoms	vi 429
Burns, Maudie Marie		Fulton, John F.	
A Family History Influences Treatment and Preven-		Aspects of Medical Defense in England	i 10
C		G	
Celentano, Luca E. (with Lewis)		Gibbons, Edward H. (with Lamoureux and Arkless)	
Sulfathiazole Treatment of Gonococcal Infections in		Tularemia in Connecticut	ix 679
Ambulatory Patients	v 344	Gildea, Edwin F. (with Kahn)	
Chester, E. P.		How to Overcome the Smoking Habit	xii 886
Vocational Rehabilitation of the Disabled Connecti-		(with Man and Riggs)	
cut Worker	iii 191	Clinical Interpretation of Blood Iodine Levels	iii 209

Gipstein, Edward		Lamoureux, Eugene L. (with Arkless and Gibbons)	
Dermatitis Caused by Nylon Stockings	iv 278	Tularemia in Connecticut	ix 679
Gold, James Douglas		Landry, Arthur B.	
An Editorial by the President	x 765	Industrial Medicine	vii 481
Message From the President	vi 439	Leichner, William (with Schaefer)	
Gold, Louis H.		Synovial Sarcoma	ii 113
Belladonna Root Treatment of Chronic Encephalitis	xi 811	Levy, Daniel F.	
Greene, Carl H.		Multiple Aneurysms of Splenic, Gastric, Renal and Superior Mesenteric Arteries	viii 567
Function of the Bile with Special Reference to Therapeutic Use of Bile Salts	xi 804	Lewis, Robert M. (with Celentano)	
Greene, Helen M. (with Phelps)		Sulfathiazole Treatment of Gonococcal Infections in Ambulatory Patients	v 344
X-ray Examination of 8210 Selectees at Induction Center, Hartford	xii 882	Lieberman, D. Leonard	
Greenhouse, Barnett		The Appendicitis Syndrome Due to Allergy	iv 277
The Newer Insulins	iii 189		
Gurewitsch, A. D.		M	
Iontophoresis with Zinc Peroxide in the Treatment of Indolent Ulcers	ix 664	Macfarlane, Catherine	
		Progress Report on Experiment In Control of Cancer of the Uterus	xi 814
H		Mahorner, Howard	
Hamilton, Walton H.		Thrombophlebitis: With Particular Reference to Treatment	iv 243
Medicine and the Antitrust Act	xii 873	Man, E. B. (with Gildea and Riggs)	
Herrmann, Julian B.		Clinical Interpretation of Blood Iodine Levels	iii 209
Low Temperature Therapy of Malignancy	x 721	Mickle, Friend Lee (with Borman)	
Hiscock, Ira V.		Evaluation Studies of Laboratories Performing Serodiagnostic Tests for Syphilis	vi 435
Background of Public Health in Connecticut	xi 821	Miller, James Raglan	
Howard, Joseph H.		Relation of the Doctor to the Hospital	iii 165
Maternal Mortality in Connecticut	ix 646	Miller, T. Grier	
Humphrey, H. (with Coll)		Discussion of Symposium on Gastro-Enterology	ix 669
Cancer of the Colon in Twins	iv 279	Moorhead, John J.	
		Conservative Treatment in Fractures of the Neck of the Humerus	iv 267
J			
Jordan, Sara M.		N	
The Problem of the Gastric Ulcer	xii 879	Nahum, Louis H. (with Piccolo)	
		Symptoms Compelling Attention to the Heart	iv 261
K		The Clinical Congress, 1941	ix 644
Kahn, Eugen		Nickerson, Elizabeth C.	
Psychiatric Contraindications to Marriage	ix 684	Have Adults Adopted the Tablet Form of Diet?	i 45
(with Gildea)		Nueswanger, C. H.	
How to Overcome the Smoking Habit	xii 886	Congenital Urological Anomalies	ix 671
Kleiner, Simon B.			
Necessity for Recto-Sigmoidal Examination	ix 667	O	
Knowlton, Millard		Osmond, Herman A.	
Connecticut Looks at Small Pox—Then and Now	i 13	Use and Abuse of Physical Agents in Treatment of Chronic Arthritis	i 28
Planning for a Pandemic of Influenza	ii 140	Oughterson, A. W.	
Kushland, S. D.		Diagnosis of Cancer of the Stomach and Colon	vii 506
Diagnosis by Gastroscopy	ix 665	Large Bowel Cancer—Symposium from 16th Clinical Congress	xii 890
L		P	
Labensky, Alfred		Perrott, G. St. J.	
Doctor Samuel Holden Parsons Lee: His Life and Times	ii 92	Physical Status of American Young Men	xi 817
Mortality in Diabetic Coma	xii 898	Petersen, William F.	
Lahey, Frank H.		Weather and the Practice of Medicine	vi 405
Some Economic Problems by a Non-Professing Economist	iii 173		
Lahn, Louis			
Case of Wandering Spleen With Torsion of the Pedicle Simulating a Pelvic Tumor	iv 274		

DECEMBER, NINETEEN HUNDRED AND FORTY-ONE

Phelps, Paul S. (with Green)		Thompson, Clarence G.	
X-ray Examination of 8210 Selectees at Induction		Scarlet Fever Immunization	x 736
Center, Hartford	xii 882	Thoms, Herbert	
Piccolo, Pasquale (with Nahum)		Connecticut Doctors in Other Fields	v 337
Symptoms Compelling Attention to the Heart	iv 261	The New Yale Library	ix 689
Putnam, Tracy J.		Tylec, L. L.	
On the Nature and Treatment of Epilepsy	iv 257	Hypcrnephronia with Metaslases to Scapula	vi 432
R		W	
Riggs, D. S. (with Gildea and Man)		Walker, W. Bradford	
Clinical Interpretation of Blood Iodine Levels	iii 209	Osteogrenic Sarcoma	i 43
Rovenstine, E. A.		Ward, Lawrence S.	
Anesthetic Control of Abdomen	ii 88	Simultaneous Occurrence of Herpes, Zoster, and	
S		Voricella	i 41
Schaefer, Abraham (with Leichner)		Weiss, Soma	
Synovial Sarcoma	ii 113	Diet and Bright's Diseases	vii 496
Scott, Warren J.		Weld, Stanley B.	
Swimming Places and Public Health	viii 570	Early Medical Practice in Hartford County	vii 484
Spekter, Louis		Wellington, H. W.	
Crippled Children in Connecticut	ix 755	Remarks on Efficient Traction	iii 170
Steiner, Walter R.		White, Benjamin V.	
Connecticut Medical Bibliography	iv 248	Gastro-Intestinal Disturbances in Nervous and Men-	
Studdiford, William E.		tal Disorders	vi 425
Chemotherapy in Pelvic Inflammatory Disease	xi 799	White, E. C., Capt., M.C.	
Swett, Paul P.		The Doctor in the Navy	xii 922
Differential Diagnosis of Low Back Pain	v 330	Winslow, C. E. A.	
T		Medical Care for the Underprivileged	i 7
Terhune, William B.		Woodward, H. G.	
Depressive Reactions in Middle Aged Men	ii 104	Station Hospital, U. S. Army Air Base, Windsor	
Thenebe, C. L.		Locks	xii 923
Observations Upon the Simpler Technique in Scarlet		Y	
Fever Immunization	x 737	Yeager, C. F.	
		Rheumatic Heart Disease	i 19

SECTION ON GENERAL MEDICINE

For General Practitioners

ORGANIZATION MEETING

DECEMBER 18th

NEW HAVEN MEDICAL ASSOCIATION

364 WHITNEY AVENUE

DINNER AT 6:30

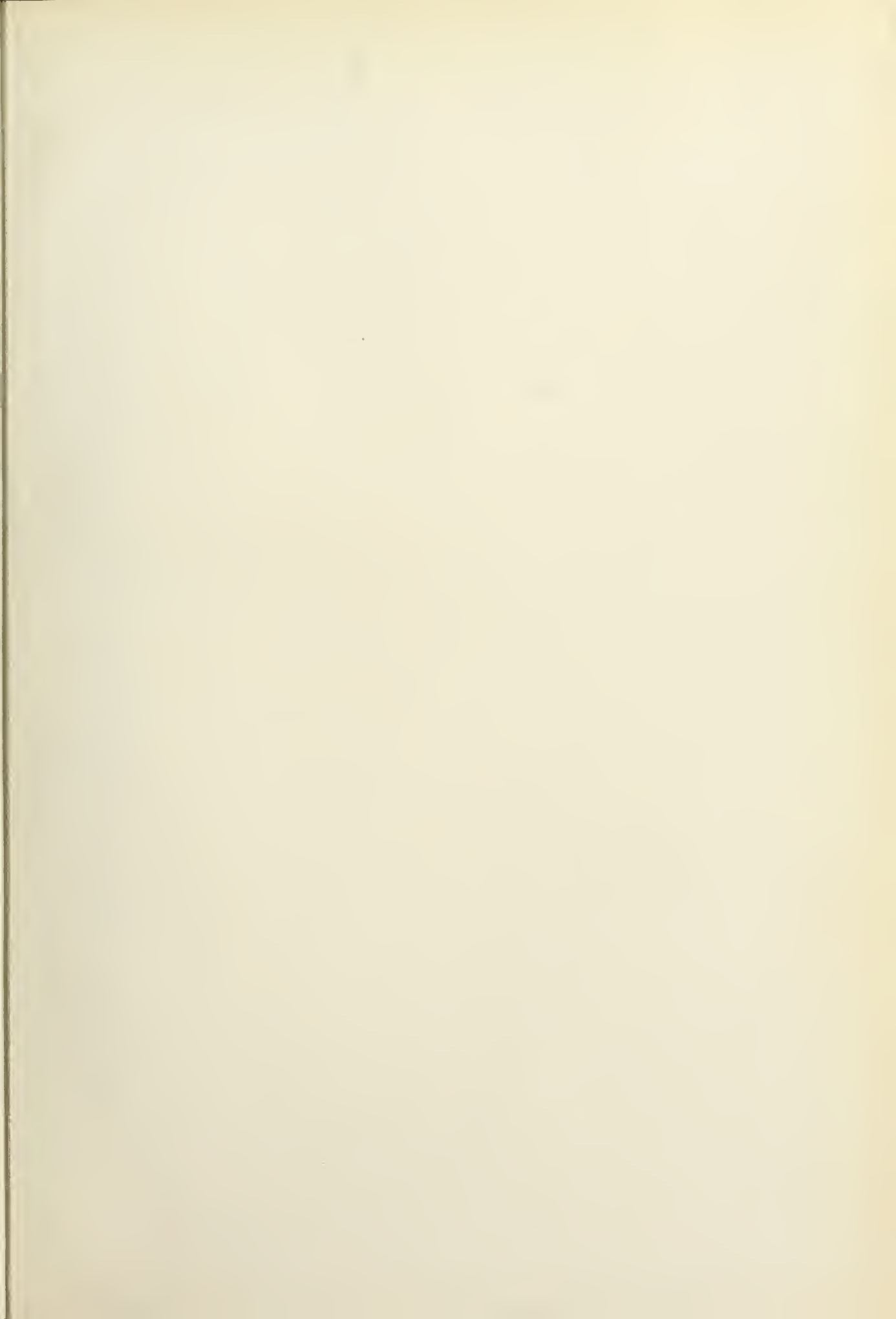
MEETING AT 8:00

Speaker

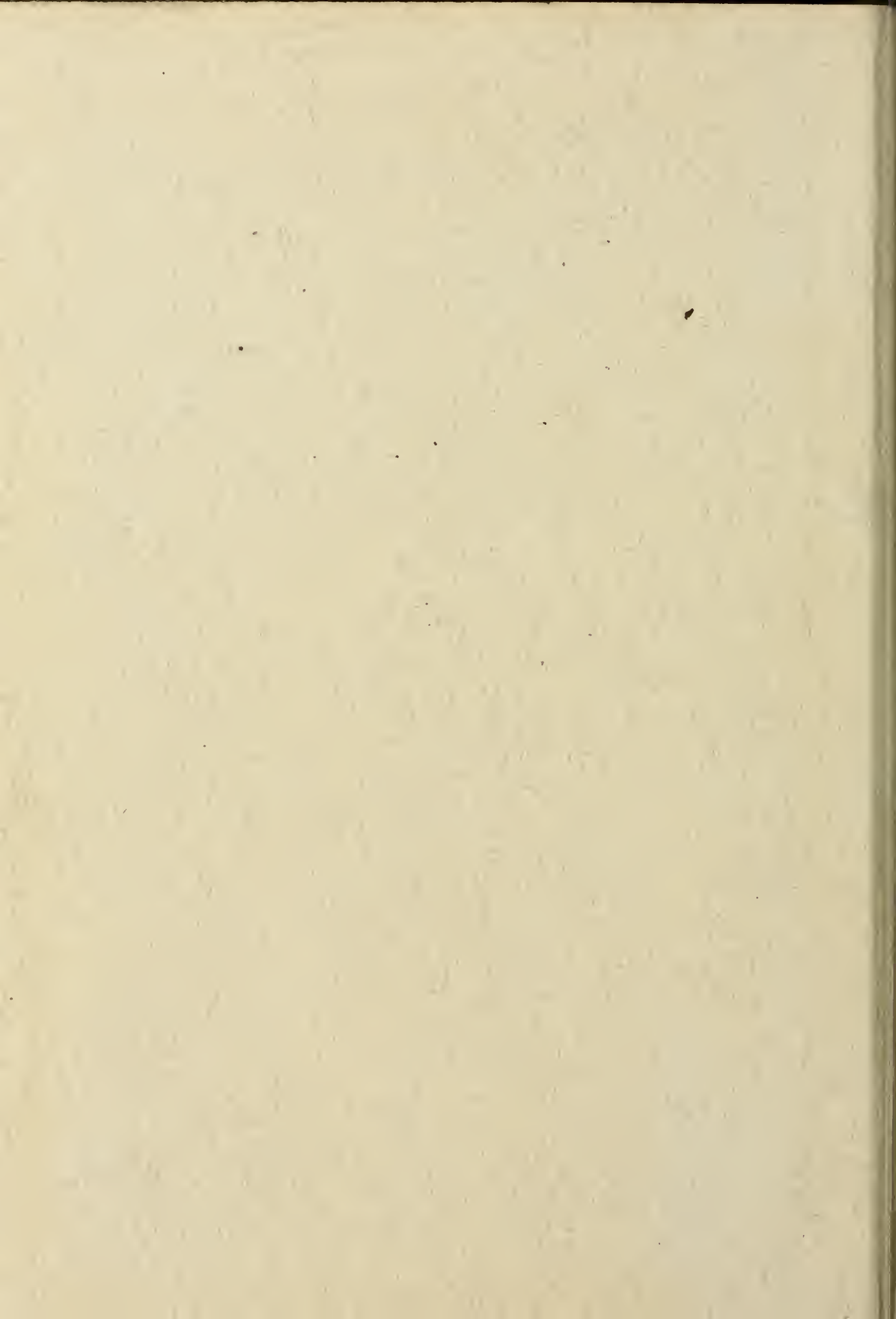
DR. HARRY E. BACON OF PHILADELPHIA

OFFICE PROCEDURES IN PROCTOLOGY









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